

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Wasshelli,

Township \_\_\_\_\_  
OR  
Village \_\_\_\_\_  
OR  
City Penick, Mo. (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 736  
Primary Registration District No. 4440

File No. 3048  
Registered No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Elizabeth Davis

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED widow WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH February 1, 1846  
(Month) (Day) (Year)

AGE 69 yrs. 11 mos. 6 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House keeper  
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) South Wales

PARENTS  
NAME OF FATHER William Walters  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Wales  
MAIDEN NAME OF MOTHER Ann Davis  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Wales

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Miss Ann Davis  
(ADDRESS) Penick, Mo

Filed Jan 30, 1916 Henry Kimbrough REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 21, 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January 19, 1916, to Jan 21, 1916, that I last saw her alive on Jan 21, 1916 and that death occurred, on the date stated above, at 4:30 P.

The CAUSE OF DEATH\* was as follows:  
Lagrippe & Catarrh of Bronchial tubes  
11th Street (by Pneumonia)  
106 D  
107 D (Duration) \_\_\_ yrs. \_\_\_ mos. 4 ds.

Contributory Pneumonia (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 2 ds.  
(Signed) W. R. Terrill M. D.  
Jan 27, 1916 (Address) Penick Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Penick, Mo DATE OF BURIAL Jan 24, 1916

UNDERTAKER Martin Mahan ADDRESS Penick, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthensia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

County *Randolph*

REGISTRARS SHALL NOT RECEIVE  
A FEE FOR CERTIFICATES UNTIL THEY  
ARE COMPLETED AS PRESCRIBED BY  
LAW

CERTIFICATE OF DEATH

Township  
or  
Village  
or  
City *Renick Mo.*

Registration District No. *736*  
Primary Registration District No. *4440*

File No.  
Registered No. *4*

If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number.]

**2 FULL NAME** *Elizabeth Davis*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OF RACE *W.* 5 SINGLE MARRIED WIDOWED OR DIVORCED *W.*  
(Write the word)

6 DATE OF BIRTH  
(Month) (Day) (Year)

7 AGE  
If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(City or town, State or foreign country)

PARENTS  
10 NAME OF FATHER  
11 BIRTHPLACE OF FATHER  
(City or town, State or foreign country)  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER  
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)  
(Address)

15  
Filed *Mar 15 1916* *Henry Kumbrough*  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan. 21 1916*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from  
191 to 191  
that I last saw him alive on 191  
and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:  
*La Grippe + Bronchitis*  
*Broncho Pneumonia*  
(Duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary) *Pneumonia*  
(Duration) yrs. mos. ds. *3*  
(Signed) *W. R. Linnell* M. D.  
*1-27 1916* (Address) *Renick Mo.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
ADDRESS 191

20 UNDERTAKER

SUPPLEMENTARY

Original file, date *1916*, 19.....

All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

3048

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