

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

PLACE OF DEATH  
County Barry  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Monett Mo. (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 30 File No. 17656  
Primary Registration District No. 3003 Registered No. 38

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

FULL NAME Elen May Wilson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 26, 1917  
(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. X ds. If LESS than 1 day, 4 hrs. or \_\_\_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Monett Mo

PARENTS  
NAME OF FATHER Bert Wilson  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Billings Mo.  
MAIDEN NAME OF MOTHER Eva Brafford  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Monett Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Noah L. Davis  
(ADDRESS) Monett Mo

Filed 527 1917 J. M. West REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 27, 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 26, 1917, to \_\_\_\_\_, 1917, that I last saw her alive on May 26, 1917, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:  
Transition

159  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Carlos Copeland M. D.  
May 27, 1917 (Address) Monett 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 Oakdale Cem DATE OF BURIAL 5/27/17  
UNDERTAKER McCallaway ADDRESS Monett Mo

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_  
 or Village \_\_\_\_\_  
 or City \_\_\_\_\_

Registration District No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_  
 (NO. \_\_\_\_\_)

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

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

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____	(Month) _____ (Day) _____ (Year) _____	
AGE _____ yrs. _____ mos. _____ ds.		If LESS than 1 day _____ hrs. or _____ min.?
OCCUPATION _____	(a) Trade, profession, or particular kind of work	
	(b) General nature of industry, business, or establishment in which employed (or employer)	

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_, 191 \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191 \_\_\_\_\_, to \_\_\_\_\_, 191 \_\_\_\_\_, that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 191 \_\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

**BIRTHPLACE** \_\_\_\_\_ (City or town, State or foreign country)

**NAME OF FATHER** \_\_\_\_\_

**BIRTHPLACE OF FATHER** \_\_\_\_\_ (City or town, State or foreign country)

**MAIDEN NAME OF MOTHER** \_\_\_\_\_

**BIRTHPLACE OF MOTHER** \_\_\_\_\_ (City or town, State or foreign country)

**Contributory** \_\_\_\_\_ (SECONDARY)

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

\_\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\* 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 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

**THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191 \_\_\_\_\_, \_\_\_\_\_

REGISTRAR \_\_\_\_\_

**PLACE OF BURIAL OR REMOVAL** \_\_\_\_\_

**DATE OF BURIAL** \_\_\_\_\_, 191 \_\_\_\_\_

**UNDERTAKER** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

1 PLACE OF DEATH

County Bany  
 Township Monett  
 Village Monett  
 City Monett

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

Registration District No. 30 File No. 38  
 Primary Registration District No. 3003 Registered No. 38  
 (NO. 30 St. 3003 Ward 38)

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

2 FULL NAME

Ellen May Wilson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED S  
 (Write the word)

6 DATE OF BIRTH (Month) 1 (Day) 1 (Year) 1917

7 AGE (yrs. 1 mos. 1 ds.) 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).....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27 1917  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1917 to 1917, that no satisfactory information supplied and that death occurred, on the date stated above, at 1917 m.

The CAUSE OF DEATH\* was as follows:  
Inaction with pneumonia with cause unknown  
 (Duration)..... yrs. 15 mos. 15 ds.

10 NAME OF FATHER.....

11 BIRTHPLACE OF FATHER (City or town, State or foreign country).....

12 MARDEN NAME OF MOTHER.....

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country).....

CONTRIBUTOR (Secondary) 151  
 (Signed) Carlos Lopez M. D.  
May 27, 1917 (Address).....

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

\*State the Disease Causing Death, or, in death 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 3 yrs. 3 mos. 3 ds. In the State..... yrs. 3 mos. 3 ds.

Where was disease contracted if not at place of death?..... Former or usual residence.....

15 Filed 5/27 1917 7 AM West Registrar

19 PLACE OF BURIAL OR REMOVAL..... DATE OF BURIAL..... 1917  
 20 UNDERTAKER..... ADDRESS.....

# Revised United States Standard Certificate of Death

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

17658

**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*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);

*Tuberculosis of lungs, meninges, peritonaeum, 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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), 29ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "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 septicaemia," "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.)