

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

8228

1 PLACE OF DEATH

County Clay
Township ~~St. Louis~~
or
Village
or
City Excelsior Springs (NO. 809 Old Orchard ~~or Ave.~~ Ward)

Registration District No. 198 File No. _____

Primary Registration District No. 3011 Registered No. 45

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

2 FULL NAME Annabel Bates

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female **4 COLOR OR RACE** White **5 SINGLE MARRIED WIDOWED OF DIVORCED** Single
(Write the word)

6 DATE OF BIRTH Feb. 7, 1918
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
_____ yrs. 1 mos. 23 ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)

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

PARENTS

10 NAME OF FATHER L. E. Bates

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

12 MAIDEN NAME OF MOTHER Bessie Bantourie

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Bates
(Address) Excelsior Springs, Mo.

15 Filed Mar 31 1918 J. H. Crover
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 30, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 3/28, 1918, to 3/29, 1918, that I last saw h alive on 3/28, 1918, and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:
9
10/19 Pneumonia
(Duration) _____ yrs. _____ mos. 6 ds.

CONTRIBUTORY Whooping Cough
(Secondary) (Duration) _____ yrs. _____ mos. 20 ds.

Signed) J. H. Crover M. D.
Mar. 31, 1918 (Address) Excelsior Springs, 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. 1 mos. 23 ds. In the State _____ yrs. 1 mos. 23 ds.

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

19 PLACE OF BURIAL OR REMOVAL Salon Church Yard **DATE OF BURIAL** Mar. 31, 1918

20 UNDERTAKER E. E. Emblove **ADDRESS** Excelsior Springs Mo.

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, 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 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 "*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.)

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(NO. 809. at anchor m Ward)

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

2 FULL NAME Annabel Bates

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Mar 30 1918
(Month) (Day) (Year)

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

17 I HEREBY CERTIFY, that I attended deceased from _____, 1918, to _____, 1918, that I last saw him alive on Mar 27 1918, and that death occurred, on the date stated above, at _____ m.

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day _____ hrs. or _____ min.?

The CAUSE OF DEATH was as follows:

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

Broncho-Pneumonia

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

CONTRIBUTORY (Secondary) Whooping Cough
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Dr. J. V. Rice M. D.
1918 (Address) _____

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) _____

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Former or usual residence _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 1918

15 Filed Mar 31 1918 J. V. Rice Registrar

20 UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.

PARENTS

Revised United States Standard Certificate of Death

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