MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

V. S. No. 2.

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

PLACE OF DEATH

County [illegible]

Township [illegible] or Village ——— or City ———(NO. ——— St.; ——— Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

Registration District No. 577

Primary Registration District No. 3775

File No. 13252

Registered No. 7

FULL NAME [illegible] Parker

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH
SEX: Female	COLOR OR RACE: White	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Maiden	DATE OF DEATH: April (Month) 21 (Day), 1914 (Year)
DATE OF BIRTH: April (Month) 21 (Day), 1902 (Year)			I HEREBY CERTIFY, that I attended deceased from April 17, 1914, to April 21, 1914, that I last saw her alive on April 21, 1914, and that death occurred, on the date stated above, at 7 P m.
AGE: 12 yrs. ——— mos. ——— ds.		If LESS than 1 day, ——— hrs. or ——— min.?	The CAUSE OF DEATH* was as follows: [illegible] (Duration) ——— yrs. ——— mos. 5 ds.
OCCUPATION (a) Trade, profession, or particular kind of work: Farmers Girl (b) General nature of industry, business, or establishment in which employed (or employer) ———			Contributory (SECONDARY) ——— (Duration) ——— yrs. ——— mos. ——— ds.
BIRTHPLACE (City or town, State or foreign country): Morgan Co Mo			(Signed) H E [illegible] M. D.
PARENTS — NAME OF FATHER: Isreal Parker			[illegible] 22, 1914 (Address) [illegible]
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
MAIDEN NAME OF MOTHER: Barbary Suter			LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ——— yrs. ——— mos. ——— ds. In the State ——— yrs. ——— mos. ——— ds.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio			Where was disease contracted if not at place of death? ———
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) [illegible] (ADDRESS) [illegible] Mo			Former or usual residence ———
			PLACE OF BURIAL OR REMOVAL: [illegible] — DATE OF BURIAL: April 23, 1914
Filed Apr 24, 1914 L L Lathrum REGISTRAR			UNDERTAKER: [illegible] — ADDRESS: [illegible]

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, Compositor, 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 *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.)

HUGH STEPHENS, JEFFERSON CITY.

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

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

PLACE OF DEATH

County Montgomery

Township Pilot Grove

or Village

or City

Registration District No. 577

Primary Registration District No. 3770

File No.

Registered No. 7

(No. St.; Ward)

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

FULL NAME Lula Garber

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) S

DATE OF BIRTH ____ (Month) ____ (Day) 1 ____ (Year)

Satisfactory Information Supplied.

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)

Satisfactory Information Supplied.

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

Satisfactory Information Supplied.

MAIDEN NAME OF MOTHER

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

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed Apl 24 191 4 L L Latham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apl 21 (Month) (Day) 191 4 (Year)

I HEREBY CERTIFY, that I attended deceased from ____ 191__, to ____, 191__, that I last saw h__ alive on ____, 191__, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Pneumonia with Chronic Comp - of Lungs - Lobar

(Duration) 1 yrs. ____ mos. 5 ds.

Contributory (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H E Blaes Jr M. D.

Apl 22 191 4 (Address) Hallsville 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

Satisfactory Information Supplied.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ____ 191__

UNDERTAKER

ADDRESS

Original file, date ____ 19__

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

SUPPLEMENTARY

NOTE—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]

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