

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.

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

1 PLACE OF DEATH  
County Nether  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City Piedra (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 668 File No. \_\_\_\_\_  
Primary Registration District No. 8032 Registered No. 39046  
310

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

2 FULL NAME Marynie Brunk

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>F</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>	16 DATE OF DEATH <u>Nov. 29</u> , 191 <u>7</u> (Month) (Day) (Year)	
6 DATE OF BIRTH _____, 1_____, 1_____ (Month) (Day) (Year)			17 I HEREBY CERTIFY, that I attended deceased from <u>Nov. 26</u> , 191 <u>7</u> , to <u>Nov. 29</u> , 191 <u>7</u> that I last saw her alive on <u>Nov 29</u> , 191 <u>7</u> and that death occurred, on the date stated above, at <u>4:30 P.M.</u>	
7 AGE <u>22</u> yrs. _____ mos. _____ ds.		8 IF LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>1451 Sepsis metastis following chedbirth</u> <u>150R</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)			(Duration) _____ yrs. _____ mos. <u>7</u> ds.	
9 BIRTHPLACE (City or town, State or foreign country) <u>Mrs.</u>			CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	10 NAME OF FATHER <u>O. J. S. Olson</u>		(Signed) <u>Chas. S. Olson</u> M. D.	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Hennepin</u>		(Address) <u>Sedalia Mo.</u>	
	12 MAIDEN NAME OF MOTHER <u>Anna Chamberlain</u>		*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mrs.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harford Brunk</u> (Address) <u>Luxton Mo.</u>				
15 Filed <u>Nov 29</u> , 191 <u>7</u> <u>J. B. Long</u> Registrar <u>per E. J. Murphy</u>				
19 PLACE OF BURIAL OR REMOVAL <u>California Mo.</u>			DATE OF BURIAL <u>Nov. 30</u> , 191 <u>7</u>	
20 UNDERTAKER <u>McLain &amp; Co.</u>			ADDRESS <u>Sedalia</u>	

# 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 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.)

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.

## 1 PLACE OF DEATH

County Pettis  
 Township.....  
 or  
 Village.....  
 or  
 City Sedalia

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

BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

Registration District No. 668 File No. ....  
 Primary Registration District No. 3032 Registered No. 310  
 (NO. .... St. .... Ward)

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

2 FULL NAME Maymie Brunke

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>m.</u>
6 DATE OF BIRTH <u>Don't know</u> (Month) (Day) (Year)		
7 AGE <u>about 22</u> yrs. mos. 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)		
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 Jan 5 1918J. B. Long

Registrar

per E. J. Deputy

Original file, date....., 19.....

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 29, 1917  
 (Month) (Day) (Year)

17 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..... m.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY  
 (Secondary)

(Signed)..... 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.

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

20 UNDERTAKER

ADDRESS

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

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