

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

PLACE OF DEATH

County Shannon
Township Montic
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 825 File No. 23309
Primary Registration District No. 6085- Registered No. 2

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

FULL NAME Nellie Irene Beaver

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH May 27, 1914
(Month) (Day) (Year)

DATE OF BIRTH Sept 10, 1881
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 26, 1914, to May 27, 1914, that I last saw her alive on May 27, 1914, and that death occurred, on the date stated above, at _____ m.

AGE 8 yrs. 12 mos. 12 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Burns from a 1060 burning building 180
(Duration) _____ yrs. _____ mos. 2 ds.

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) 0

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

PARENTS NAME OF FATHER Robert James Beaver BIRTHPLACE OF FATHER (City or town, State or foreign country) Illinois MAIDEN NAME OF MOTHER Lucy Pastor BIRTHPLACE OF MOTHER (City or town, State or foreign country) Illinois

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) C. A. Wright M. D. June 16, 1914 (Address) Montic Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Clara Beaver (ADDRESS) Montic 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 _____

Filed June 16, 1914, C. A. Wright REGISTRAR

PLACE OF BURIAL OR REMOVAL Montic DATE OF BURIAL May 28, 1914 ADDRESS _____ UNDERTAKER No undertaker

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, Sar-*

coma, 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.)



PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty ShannonTownship MontevRegistration District No. 825File No. 23309

Village _____

Primary Registration District No. 6085Registered No. 2

City _____ (NO. _____)

St.: _____ Ward _____

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

FULL NAME Nellie Irene Beaver

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Sept. 10</u> , 19 <u>11</u> (Month) (Day) (Year)		
AGE <u>8</u> yrs. <u>17</u> mos. <u>17</u> 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) _____		

BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>	
PARENTS	NAME OF FATHER <u>Robert James Beaver</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Illinois</u>
	MAIDEN NAME OF MOTHER <u>Lacy Paxton</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Illinois</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Beaver
(ADDRESS) Montev Mo.

Filed June 16, 1911. C. A. Wright
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH <u>May 27</u> , 19 <u>11</u> (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from <u>May 26</u> , 19 <u>11</u> , to <u>May 27</u> , 19 <u>11</u> , that I last saw her alive on _____, 19 <u>11</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Burns from a burning building</u>
(Duration) _____ yrs. _____ mos. <u>2</u> ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. A. Wright M. D.
June 16, 1911 (Address) Montev 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 <u>Montev</u>	DATE OF BURIAL <u>May 27</u> , 19 <u>11</u>
UNDERTAKER <u>No undertaker</u>	ADDRESS _____

Original file, date June 16, 1911

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]

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