

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

PLACE OF DEATH

County Webster
Township Washington
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 899
Primary Registration District No. 6206

File No. 18820
Registered No. 9

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

FULL NAME Lura Harriet Day

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH May 22, 1913
(Month) (Day) (Year)

DATE OF BIRTH March 20, 1895
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from Oct 2, 1912 to May 22, 1913, that I last saw her alive on April 10, 1913, and that death occurred, on the date stated above, at 5 a.m.

AGE 18 yrs. 2 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work None 9-30
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

Tuberculosis
23A

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

(Duration) yrs. 7 mos. ds.

NAME OF FATHER A. P. Day

Contributory (SECONDARY) (Duration) yrs. mos. ds.

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

(Signed) John M. Bruce, M.D.
5/22/13 (Address) Marshallfield Mo.

MAIDEN NAME OF MOTHER Kate Hedrick

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) Earl Day

Former or usual residence _____

(ADDRESS) Marshallfield Mo.

PLACE OF BURIAL OR REMOVAL St. Luke DATE OF BURIAL May 23, 1913

Filed May 23, 1913 E. M. Boies REGISTRAR

UNDERTAKER W. M. Mahan ADDRESS Marshallfield Mo.

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.

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*, *peritoneum*, 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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

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

County Webster
 Township Washington
 or
 Village _____
 or
 City _____

Registration District No. 899 File No. _____
 Primary Registration District No. 6206 Registered No. 9
 (NO. _____ St.: _____ Ward _____)

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

FULL NAME Lura Harriet Way.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Satisfactory Information Supplied. COLOR OR RACE _____ SINGLE MARRIED Widowed (If widowed, give name of deceased. If divorced, give name of husband.)
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 AGE _____ yrs. _____ mos. _____ ds. (If less than 1 year, give in mos. or mths.)
 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) _____
 PARENTS
 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) _____

DATE OF DEATH May 22, 1913
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 191, to _____, 191,
 that I last saw him alive on _____, 191,
 and that death occurred, on the date stated above, _____, 191.
 The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory (Secondary) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. B. Bruce M. D.
5722, 1913 (Address) Marshfield
 *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 _____

SUPPLEMENTARY Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Satisfactory information Supplied.
 (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191
Satisfactory Information Supplied.
 UNDERTAKER _____ ADDRESS _____
Satisfactory Information Supplied.

Filed 5, 23 1913 Em Bailey REGISTRAR

Revised United States Standard Certificate of Death

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

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