

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

PLACE OF DEATH
County St. Francois
Township St. Francois
or
Village
or
City Farmington (NO. _____ St. _____ Ward _____)

Registration District No. 773 File No. 2286
Primary Registration District No. 4018^a Registered No. 381

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

FULL NAME Mary E. Golan

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan 13th, 1914
(Month) (Day) (Year)

DATE OF BIRTH Apr 5, 1877
(Month) (Day) (Year)

AGE 36 yrs. 9 mos. 7 ds. IF LESS than
1 day, ___ hrs. or ___ min. ?

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

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

PARENTS
NAME OF FATHER Thomas C Golan
BIRTHPLACE OF FATHER Ohio
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Eliza Golan
BIRTHPLACE OF MOTHER St. Francois Co Mo.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Bethe Golan
(ADDRESS) Farmington Mo.

Filed Jan 14th 1914 B. R. Downing
REGISTRAR

I HEREBY CERTIFY, that I attended deceased from August 1st, 1913, to Jan 12th, 1914, that I last saw her alive on Jan 12th, 1914, and that death occurred, on the date stated above, at about noon.

The CAUSE OF DEATH* was as follows:
Apoplexy, embolism of
82A the brain,
82B

Contributory Cellulitis
(Duration) yrs. 5 mos. 1 ds.
(Signed) Frank S. Kehr M. D.
Jan. 14th, 1914 (Address) Farmington 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 36 yrs. 9 mos. 7 ds. In the 36 yrs. 9 mos. 7 ds.
of death
Where was disease contracted at place of death
if not at place of death?
Former or St. Francois Co.
Usual residence

PLACE OF BURIAL OR REMOVAL St. Francois Co. DATE OF BURIAL Jan. 15th, 1914

UNDERTAKER Farmington Undertaking Co., Farmington Mo. ADDRESS

B- Every item of information should be carefully supplied. If E should be omitted, it should be so indicated. 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, 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.)

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

PLACE OF DEATH
County St. Francois
Township St. Francois
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 773

File No. _____

Primary Registration District No. 6018ARegistered No. 381

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

FULL NAME Mary E. Golman

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) _____

AGE _____

IF LESS than
1 day, _____ hrs.
or _____ min.

_____ yrs. _____ mos. _____ ds.

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 E. Golman

BIRTHPLACE OF MOTHER _____

(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed Jan 19 19141914REGISTRAR B. R. DowningN. D.Original file, No. Jan1914

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 13 1914

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1914 to _____, 1914,that I last saw h _____ alive on _____, 1914,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: _____

Contributory _____

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

M. D. _____

(Address) _____

*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 _____

DATE OF BURIAL _____ 1914

UNDERTAKER _____

ADDRESS _____

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

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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