

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
County St. Francois
Township "
or Flat River
Village "
or "
City " (NO. " St. " Ward ")
Registration District No. 774 File No. 14255
Primary Registration District No. 4463 Registered No. 29

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

FULL NAME Mary Elizabeth Covington

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (If write the word)
DATE OF BIRTH <u>March 31</u> , 19 <u>13</u> (Month) (Day) (Year)		
AGE <u>77</u> yrs. <u>9</u> mos. <u>27</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Q - O</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Robertson County Tenn</u>		
PARENTS	NAME OF FATHER <u>Nough Shannon</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tenn.</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth Shannon</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jennie Strong
(ADDRESS) Farmington, RR #2
Filed Apr 1, 1913, Dr Topping
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 31, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 27, 1913, to Mar 31, 1913,
that I last saw her alive on Mar 31, 1913,
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia ✓

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory Old age
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. L. Keith M. D.
Apr 1, 1913 (Address) Marion 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 Bonnie Terrace No. DATE OF BURIAL April 2, 1913

UNDERTAKER Henry Rink ADDRESS Flat River Mo

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.)

PLACE OF DEATH

County St. Francis

Township _____

or Village Flat River

or City _____ (NO. _____)

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

FULL NAME

Mary Elizabeth Levington.

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

W.SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)M.

DATE OF BIRTH

March 31, 1913
(Month) (Day) (Year)

AGE

77 yrs. 9 mos. 27 ds.If LESS than
1 day, ____ hrs.
or ____ min.

OCCUPATION

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

BIRTHPLACE

(City or town,
State or foreign country)Roberson Co. Tenn.

PARENTS

NAME OF
FATHERHugh ShanonBIRTHPLACE
OF FATHER
(City or town, State or foreign country)Tenn.MAIDEN NAME
OF MOTHERElizabeth ShanonBIRTHPLACE
OF MOTHER
(City or town, State or foreign country)Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Jennie Strous

(ADDRESS)

Farmington R.R.

Filed

Apr 1, 1913 Dr. Topping

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar. 31, 1913
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from
Mar. 27, 1913, to Mar. 31, 1913,
that I last saw him alive on Mar. 31, 1913,
and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar Pneumonia

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

Contributory Old age
(SECONDARY)

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

(Signed) H. G. Keith M. D.
Apr. 1, 1913 (Address) Flat River 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. State ____ yrs. ____ mos. ____ ds.Where was disease contracted
if not at place of death?Former or
usual residence.

PLACE OF BURIAL OR REMOVAL

Bonne Terre Mo.

DATE OF BURIAL

Apr. 2, 1913

UNDERTAKER

Henry Burke

ADDRESS

Flat River Mo.Original file, date Apr - 1913, 19

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

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14255
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.)