

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. See instructions on back of certificate.

1 PLACE OF DEATH  
County Garnett (No. 188)  
Village or City Swanton (No. 11) (Ward) 1st  
2 FULL NAME Daniel Edward Beckman  
STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 768  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male  
4 COLOR OR RACE White  
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 7, 1856  
(Month) (Day) (Year)

7 AGE 62 yrs. 11 mos. 24 ds.  
IF LESS THAN 1 day, hrs. OR min. ?

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

9 BIRTHPLACE (State or country) Allegheny, Md.

10 NAME OF FATHER Rudolph Beckman

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Oliver

13 BIRTHPLACE OF MOTHER (State or country) Allegheny Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. E. Beckman

(Address) Swanton, Md.

15 June 1, 1919 Mrs. C. A. Haskins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31, 1919  
(Month) (Day) (Year)

17 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, at 1 P.m.

The CAUSE OF DEATH \* was as follows: ?

Present illness on general information

(Duration) yrs. mos. ds.

Contributory Secondary Swamp (Duration) yrs. mos. ds.

(Signed) H. W. McComas M. D.

June 1, 1919 (Address) Orlando, Md.

\* 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 North Glade DATE OF BURIAL June 1, 1919

20 UNDERTAKER D. E. Bulcher ADDRESS Orlando

# 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 *Plumber*; *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) *Crocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Prep.," etc. without more precise specification as *Day laborer from laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only, but 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 name accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningeal*; *Hooping cough*; *Chronic tubular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meningeal disease causing death*, 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asbestic," "Anemic" (merely symptomatic), "Atrophy," "Calciplex," "Cama," "Convulsions," "Debility," ("Cerebral," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmation," "Marasmus," "Old Age," "Stroke," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal *epidemic*," "Prenatal *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—homicidal*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *apoplex*, *hemiparesis*) 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.)

If the certificate is looked over, harmonized, and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is peremptorily filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

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 See instructions on back of certificate

V. S. No. 1

1 PLACE OF DEATH  
 County Gorham 06843 (10)  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH  
 Registration Dist. No. 166  
 Village or City Cockeysville (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward)  
 2 FULL NAME Helen Eliza Beckman  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE MARRIED, WIDOWED OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Dec 28 1915  
(Month) (Day) (Year)

7 AGE 19 yrs. 4 mos. 3 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) md, York Co

PARENTS  
 10 NAME OF FATHER Wayman Beckman  
 11 BIRTHPLACE OF FATHER (State or country) md  
 12 MAIDEN NAME OF MOTHER Grace White  
 13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Joseph Beckman  
 (Address) Cockeysville md

15 Filed May 2 1919 by Julia Rowan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 1st 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 22 1919 to May 1st 1919, that I last saw her alive on April 30, 1919, and that death occurred on the date stated above, at 7:25 m.

The CAUSE OF DEATH \* was as follows:  
influenza

(Duration) yrs. mos. ds.  
 Contributory Heart Disease

(Duration) yrs. mos. ds.  
 (Signed) M. C. Hunsbarger  
May 1 1919 (Address) Cockeysville md

\*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 St. Pauls DATE OF BURIAL May 2 1919

20 UNDERTAKER D. C. Holden ADDRESS Cockeysville

# 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*, *Mill 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) *Manager of Foreman*, (b) *Automobile factory*. The material covered on may form part of Foreman, a Manager, or Foreman, etc., without more precise specification as *Day laborer*, *Form 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*, *menin-*

*gea*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*. If *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 da., *Bronchopneumonia* (secondary), 10 da. Never report mere symptoms or terminal conditions, such as "Asystole," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Hobbley" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Insanition," "Aneurism," "Old Age," "Shock," "Erythra," "Workman," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal," *epithelioma*, "Prenatal peritonitis," etc. State cause (or which surgical operation was undertaken. For violence or state means or injury and qualify as ACCIDENTAL, FETTERAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by falling train—accident*, *Reveler wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *epilepsy*, *deafness*) 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.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

Village or City Stanton, Md.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 166

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

2 FULL NAME John M. Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct 8, 1853  
(Month) (Day) (Year)

7 AGE 66 yrs. 6 mos. 22 ds. If LESS than 1 day, ... hrs. OR ... min. ?

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

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Perennial Brown

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Dick

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John R. Brown

(Address) Arden Ohio

15 Filed May 3, 1919 Julia Rowan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 1st, 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1916, to May 1, 1919, that I last saw him alive on April 25, 1919, and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH \* was as follows:  
Heart insufficiency

(Duration) ... yrs. ... mos. ... ds.  
Contributory Rheumatic valvular  
Secondary  
(Signed) H. W. McBurns M. D.  
May 2, 1919 (Address) Oakland Md

\*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 Oakland Md DATE OF BURIAL May 3, 1919

20 UNDERTAKER D. C. Baldwin ADDRESS Oakland

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

**Statement of Occupations**—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 *Plumber*, *Pigstian*, *Compositor*, *Architect*, *Locomotive engineer*, *Cart 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) *Auto-mobile 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"); *Dysphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic subacute heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Gama," "Convulsions," "Debility," ("Congital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal eclampsia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state means or injury and qualify as ACCIDENTAL, SELF-KILL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Roadster 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.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

1 PLACE OF DEATH

County Garrett County

Village or City Newport W. Va. (No. 06845)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 167

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

2 FULL NAME Baby Downey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 5, 1919  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, 4 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 (State or country) Maryland

PARENTS  
10 NAME OF FATHER Clyde S Downey  
11 BIRTHPLACE OF FATHER (State or country) Henry W. Va.  
12 MAIDEN NAME OF MOTHER Alice Jane Bray  
13 BIRTHPLACE OF MOTHER (State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Clyde S Downey  
(Address) Newport W. Va.

15 Filed May 6, 1919 L. W. Abernathy  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5, 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1919, to May 5, 1919, that I last saw her alive on May 5, 1919, and that death occurred on the date stated above, at 3:30 m.

The CAUSE OF DEATH \* was as follows:  
Premature Birth  
(about 7 months)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) C. T. Kerran M. D.  
May 6, 1919 (Address) Newport W. Va.

\*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 \_\_\_\_\_ 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 C. F. Ryan Cem. DATE OF BURIAL May 6, 1919

20 UNDERTAKER F. C. Hollman ADDRESS Thomas W. Va.

# 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 foreman*, 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) *Tobacco*; (a) *Foreman*, (b) *Auto-mobile 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*, *menin-*

*ges 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), *23 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asplenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "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*; *Rampole wound of head—homicide*; *Poisoned by carbonic 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.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

V. S. No. 1.

## PLACE OF DEATH

County

*Garrett*

0646

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*166*

Village or City

*Dyersville* (No. \_\_\_\_\_)

St.; Ward)

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

\* FULL NAME

*Annis May Edger*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*  
(Write the word)

6 DATE OF BIRTH *Apr 24 1900*  
(Month) (Day) (Year)

7 AGE *19* yrs. mos. *10* ds. *13* OR LESS than 1 day, hrs. OR min. ?

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

9 BIRTHPLACE (State or country) *Md.*

10 NAME OF FATHER *John A. Edger*

11 BIRTHPLACE OF FATHER (State or country) *Pa*

12 MAIDEN NAME OF MOTHER *Julia H. Bowman*

13 BIRTHPLACE OF MOTHER (State or country) *Pa*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *B. L. Bowman*(Address) *Mc Henry Md*

15 Filed *May 7 1919* *Julia Kowan*  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 6th 1919*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *April 30th 1919* to *May 6th 1919*.

that I last saw him alive on *May 6th 1919*.

and that death occurred on the date stated above, at *8:15* m.

The CAUSE OF DEATH \* was as follows:

*Suppurating Pneumonia*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *P. A. Rarusoff*, M. D.  
*May 7th 1919* (Address) *Accident Md*

\* 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

*Dyersville* *May 7 1919*

20 UNDERTAKER

ADDRESS

*D. E. Peltier* *Red Bank Md*

# 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 *Painter*. *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) *Proctor*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer."  
"Foreman," "Manager," "Painter," 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 name accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, menia-

*ges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc.; of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *If Hooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles* (disease causing death); *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "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*; *Renal wound of heart—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.)

If this certificate is filled over thoroughly and all questions answered in detail, it will prevent further correspondence. Write the date of completion and must be obtained before the expiration of the certificate.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Garrett*

Village or City

*Thyruville* (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*166*

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

2 FULL NAME

*Bessie Ellen Edger*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*  
(Write the word)

6 DATE OF BIRTH

*Feb 22 1903*  
(Month) (Day) (Year)

7 AGE

*16 yrs. 2 mos. 13 ds.*If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work *Home Maid*  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE

(State or country)

 *Md.* 

10 NAME OF FATHER

*John H. Edger*

11 BIRTHPLACE OF FATHER

(State or country)

 *Pa.* 

12 MAIDEN NAME OF MOTHER

*Julia A. Bowman*

13 BIRTHPLACE OF MOTHER

(State or country)

 *Pa.* 

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*J. M. Bowman*

(Address)

*McHenry Md*

15 FILED

*May 6 1919**Julia Bowman*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*May 5 1919*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*April 28 1919 to May 4 1919*that I last saw him alive on *May 4 1919*and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH was as follows:

*Influenza and Pneumonia*

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*W. P. Rousseau, M. D.**May 5 1919* (Address) *Academy St.*

\*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

*Thyruville*

DATE OF BURIAL

*May 6 1919*

20 UNDERTAKER

*W. E. B. B. B. B.*

ADDRESS

*Washington Md*

# 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, Card 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, (c) Salsman, (d) Grocery, (e) Roseman, (f) Automobile factory.* The industrial worker on any form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Lumber worker, 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 name accepted terms for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, men-*

*ges, peritonium, etc., Carcinoma, Sarcoma, etc., of* . . . . .  
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Meningeal, Whooping cough, Rheumatic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meningeal (disease causing death), 29 da.; Bronchopneumonia (secondary), 10 da.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state straits or history and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Roadster wound of head—homicide; Poisoned by carbolic disinfectant—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.)

If the certificate is checked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

V. S. No. 1

PLACE OF DEATH

County Carroll

Village or City Thyngville (No. \_\_\_\_\_)

FULL NAME Birtha Edger

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 166

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH August 26, 1888  
(Month) (Day) (Year)

AGE 30 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

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

BIRTHPLACE (State or country) W. Va.

PARENTS

10 NAME OF FATHER John A. Edger

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Julia A. Bauman

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Bauman

(Address) McHenry

FILED May 3, 1919 Julia Rowan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH May 3, 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1919, to May, 1919, that I last saw her alive on May 3<sup>rd</sup>, 1919, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH \* was as follows:  
influenza and pneumonia

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Signed) J. M. Bauman M. D.

May 3, 1919 (Address) Academy, Md.  
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 Thyngville DATE OF BURIAL May 4, 1919

20 UNDERTAKER J. M. Bauman ADDRESS \_\_\_\_\_

# 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, Field 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. An example: (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 *Housekeeper* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not actually 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: *Former (retired) etc.* 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 name accepted terms 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"); *Lebor pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria (disease causing death), 29 da.; Bronchopneumonia (secondary), 10 da.* Never report mere symptoms or terminal conditions, such as "Asphonia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsion," "Debility" ("Congestial," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal pyæmia," etc. State cause for which surgical operation was undertaken. For violent deaths state scars or injury and qualify as ACCIDENTAL, SUICIDAL, or HOSTILE, 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.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Garrett

068470

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 166Village or City Thymville (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

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

2 FULL NAME Julia A. Edgar

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow6 DATE OF BIRTH Oct 10, 1863  
(Month) (Day) (Year)7 AGE 55 yrs. 6 mos. 26 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry business, or establishment in which employed (or employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Pa10 NAME OF FATHER Moses Bowman11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Susan Bowman13 BIRTHPLACE OF MOTHER (State or country) Pa14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) B. L. Bowman(Address) McHenry Md15 May 6, 1919 Julia Rowan  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5<sup>th</sup>, 1919  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 1<sup>st</sup>, 1919, to May 5<sup>th</sup>, 1919, that I last saw him alive on May 5<sup>th</sup>, 1919, and that death occurred on the date stated above, at 6:30 m.

The CAUSE OF DEATH \* was as follows:

Influenza and PneumoniaContributory \_\_\_\_\_  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) B. L. Bowman M. D.  
May 6<sup>th</sup>, 1919 (Address) Accident 7<sup>th</sup> St

\* 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 Thymville DATE OF BURIAL May 6, 191920 UNDERTAKER D. E. Bubb ADDRESS Woodland

# 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, Tailor, 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, men-*

*ger, peritonaeum*, etc., *Cirrhosis, Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm; *Malaria*. If *hooping cough*; *chronic valvular heart disease*; *tertiary syphilitic nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, 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.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. **Fill in the blanks as carefully and must be obtained before the certificate is permanently filed.**

JUN 5 1919

BUREAU V. S.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

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 See instructions on back of certificate

V. S. No. 1

' PLACE OF DEATH

County Ga. 109

06850

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 169Village or City Deer Park No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

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

<sup>2</sup> FULL NAME Martin Filsinger

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Male <sup>4</sup> COLOR OR RACE White <sup>5</sup> SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

<sup>6</sup> DATE OF BIRTH Nov. 1, 1843  
(Month) (Day) (Year)

<sup>7</sup> AGE 73 yrs. six mos. 27 ds. If LESS than 1 day, hrs. OR min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE (State or country) Germany

<sup>10</sup> NAME OF FATHER George M. Filsinger

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Germany

<sup>12</sup> MAIDEN NAME OF MOTHER Kathrine Thomas

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Philip Filsinger(Address) Deer Park Md

<sup>15</sup> Filed May 26, 1919 W. C. A. Ashby  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH May, 1919  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from May 22, 1919 to May 25, 1919, that I last saw him alive on May 22, 1919, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Especially large double angina pectoris causing a strokeLong (Duration) 20 yrs. 6 mos. 6 ds.Contributory Angina pectoris  
Secondary

(Signed) Henry W. Thomas M. D.  
May 25, 1919 (Address) Oakland Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

<sup>18</sup> 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

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Deer Park Md DATE OF BURIAL May 27, 1919

<sup>20</sup> UNDERTAKER D. E. Balden ADDRESS Oakland Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

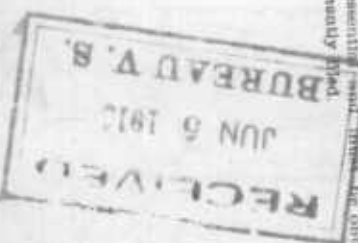
[Approved by U. S. Census and American Public Health  
Association.]

**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*, *Tail 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) *Woolery*; (a) *Farmer*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer" or "Foreman," "Manager," "Teacher," etc. "Home" here precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (and 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"); *Labor pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, 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 "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Irritability," "Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Frenzy," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means or 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*. *Rencher 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.)

If this certificate is printed over irregularly and all questions answered in detail, it will prevent further correspondence. All the data in essential items be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

PLACE OF DEATH

County

Garrett

68

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

67

Village or City

Steyer

(No.

St.; Ward)

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

FULL NAME

Tabitha Susan Harvey

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE MARRIED, WIDOWED OR DIVORCED (Write the word)

single

DATE OF BIRTH

January 18, 1884

AGE

35 yrs 4 mos 13 ds

OCCUPATION

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

Swadid.  
at home

BIRTHPLACE

(State or country)

Garrett County, MD

NAME OF FATHER

Wm. Harvey

BIRTHPLACE OF FATHER

Garrett County

MAIDEN NAME OF MOTHER

Hester Kilsbee

BIRTHPLACE OF MOTHER

Garrett County

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hester A Harvey

Address

Steyer, Md

FILED

May 31, 1919 Julia Rowan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May 31, 1919

I HEREBY CERTIFY, That I attended deceased from

May 28, 1919 to May 31, 1919

that I last saw him alive on

May 28, 1919

and that death occurred on the date stated above, at

129

The CAUSE OF DEATH \* was as follows:

Dementia

Contributory Secondary

W. G. Drinkwater  
May 31, 1919 (Address) Lomaxville, W. Va

State the DISEASE CAUSING DEATH, or, in death 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

White Church, June 1, 1919

DEP. KEEPER

Hester A. Harvey Steyer, Md

# 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*, *Coal 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 method on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Clerk," etc., without more precise specification as *Day laborer*, *Form 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 *Seaman*, *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 name accepted term for the name 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," *lobar pneumonia*, *bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*git*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningeal*, *Wooeping scuffle*, *hectic perforating heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) diseases need not be stated unless important. Example: *Meningeal disease causing death*, *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dobility," "Congenital," "Seizure," etc., "Hypoxia," "Exhaustion," "Heart failure," "Hemorrhage," "Hemiparesis," "Murmurs," "Old Age," "Shock," "Furuncle," "Weakness," etc. When a definite disease can be ascertained as the cause. Always qualify all phrases resulting from childbirth or miscarriage as "perinatal nephritis," "Perinatal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state cause or injury and qualify as accidental, ritual, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Stroke by railway train—accident*, *Kentner wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *menitis*) 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.)

If this certificate is taken over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 5 1910  
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH

County Garrett

068574 (92)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 165

Village or City Heopas (No. 7208 St.; Ward)

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

2 FULL NAME Poland Dale Hoge

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE MARRIED, WIDOWED OR DIVORCED Infant  
(Write the word)

6 DATE OF BIRTH July 3, 1918  
(Month) (Day) (Year)

7 AGE 10 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. OR mid. ?

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 (State or country) Maryland.

PARENTS

10 NAME OF FATHER Vernon Hoge

11 BIRTHPLACE OF FATHER (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Respa. J. Casteel

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vernon Hoge

(Address) Hoges. Md.

15 Filed May 9<sup>th</sup> 1919

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1<sup>st</sup> 1919, to May 7 1919, that I last saw him alive on May 7<sup>th</sup> 1919, and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH \* was as follows:  
Pneumonia

(Duration) yrs. mos. 9 ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) P. A. ... M. D. May 8, 1919 (Address) Accident Rd

\* 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 Casteel Graveyard DATE OF BURIAL May 9, 1919

20 UNDERTAKER W. H. ... ADDRESS Frederick

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

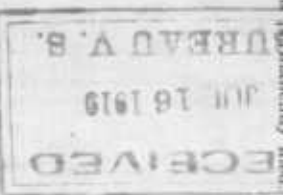
Approved by U. S. Bureau and American Public Health  
Association.

**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*, *Tire 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. Woman 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 "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *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," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachea," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "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.)

If the certificate is filled out thoroughly and all questions answered, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is appropriately filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH

County

Garnes

06852

(10)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 166

Village or City

Thayerville (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

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

2 FULL NAME

Mrs. Sophia Eysenck Lee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH March 2, 1870  
(Month) (Day) (Year)

7 AGE 49 yrs. 2 mos. 25 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

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

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER August J. Schmidt

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MARDEN NAME OF MOTHER Rachel Beckman

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sophia Lee

(Address)

Oakland Md

15 May 1, 1919 of Julia Rowan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2, 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1919 to May 2, 1919, that I last saw him alive on May 2, 1919, and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH \* was as follows:

Injury (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory Injury (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

(Signed) H. D. Prosser M. D. May 2, 1919 (Address) Oakland Md

\* 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 Thayerville DATE OF BURIAL May 4, 1919

20 UNDERTAKER D. E. Prosser ADDRESS Oakland Md

# 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) *Collon 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*, *Form laborer*, *Laborer—Cord 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*, *menin-*

*ges*, *peritonaeum*, etc. (*irritation*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesites*, *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 more symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Conlapse," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "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.)

If the certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential, and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
1 PLACE OF DEATH County <u>Garrett</u> 06853			STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>168</u>	
Village or City _____ (No. _____, St.; Ward _____)			[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Melvin Meese</u>				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>	18 DATE OF DEATH <u>May 31</u> , 191 <u>9</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Dec</u> , 19 <u>03</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, that I attended deceased from <u>May 31</u> , 191 <u>9</u> , to <u>May 31</u> , 191 <u>9</u> , that I last saw him alive on <u>May 31</u> , 191 <u>9</u> , and that death occurred on the date stated above, at <u>5:30</u> p. m.	
7 AGE <u>15</u> yrs. <u>5</u> mos. <u></u> ds. If LESS than 1 day, _____ hrs. OR min. ?			The CAUSE OF DEATH * was as follows: <u>Appendicitis</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>School</u> (b) General nature of industry, business, or establishment in which employed (or employer)			Contributory <u>Ruptured appendix</u> Secondary	
9 BIRTHPLACE (State or country) <u>Maryland</u>			(Duration) yrs. mos. <u>5</u> ds. 6/1 191 <u>9</u> (Address) <u>Frostburg Md</u>	
PARENTS	10 NAME OF FATHER <u>John Meese</u>	* State the DISEASE CAUSING DEATH, or, in deaths from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	19 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? Farmer or usual residence _____		
	12 MAIDEN NAME OF MOTHER <u>Annie A. Baer</u>	19 PLACE OF BURIAL OR REMOVAL <u>Greenville Pa</u> DATE OF BURIAL <u>6/3</u> , 191 <u>9</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Pennsylvania</u>	20 UNDERTAKER <u>J. J. Durst</u> ADDRESS <u>Frostburg Md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Meese</u> (Address) <u>Sand patch Pa.</u>				
15 Filed <u>June 2</u> , 191 <u>9</u> <u>Thomas J. Browe</u> REGISTRAR				

# 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) *Sprinter*, (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*, mena-

*ges, peritonitum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *epilepsia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, FURDIAL, or HOWDIAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corkale g-ctm—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.)

If the certificate is hooked over, thoroughly read all questions answered in detail. It will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
PLACE OF DEATH County <u>Garrett</u> (10) Village or City <u>Hayesville</u> (No. <u>06854</u> St.; Ward)		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>166</u> [If death occurred in a hospital or institution, give its NAME instead of street and number.]	
FULL NAME <u>August Lewis Schmidt,</u>			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>May 5</u> , 191 <u>9</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>October 10</u> , 18 <u>73</u> (Month) (Day) (Year)		17 I HEREBY CERTIFY, That I attended deceased from <u>from May 2<sup>nd</sup></u> , 191 <u>9</u> , to <u>May 3<sup>rd</sup></u> , 191 <u>9</u> , that I last saw him alive on <u>May 2<sup>nd</sup></u> , 191 <u>9</u> , and that death occurred on the date stated above, at <u>      </u> m.	
7 AGE <u>45</u> yrs. <u>6</u> mos. <u>25</u> ds.	IF LESS than 1 day, <u>      </u> hrs. OR <u>      </u> min.?	The CAUSE OF DEATH * was as follows: <u>Influenza</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		Contributory Secondary (Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.	
9 BIRTHPLACE (State or country) <u>Maryland</u>		(Signed) <u>W. E. Golden</u> <u>May 6<sup>th</sup></u> , 191 <u>9</u> Address <u>Oakland Md.</u>	
PARENTS	10 NAME OF FATHER <u>August Henry S.</u>	✓ State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. Where was disease contracted, if not at place of death? Former or usual residence	
	12 MAIDEN NAME OF MOTHER <u>Rachel Beckman</u>	19 PLACE OF BURIAL OR REMOVAL <u>Hayesville Md.</u> DATE OF BURIAL <u>May 7</u> , 191 <u>9</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>	20 UNDERTAKER <u>W. E. Golden</u> <u>Oakland, Md.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter L. Kahl</u> (Address) <u>Oakland, Md.</u>		15 FILED <u>May 6</u> , 191 <u>9</u> <u>Julia Rowan</u> REGISTRAR	

# 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) Scalesman, (b) Weaver, (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher" or without more precise specification as *Day laborer, Farm laborer, Laborer—Cool 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 name accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*goc, peritonaeum, etc., Carcinoma, Sarcoma, etc.* of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningeal, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meningeal* (disease causing death), *29 da., Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium," "Ergastrium," "Sepsis," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Nursing," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal *epithelioma,*" "Prenatal *peritonitis,*" etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS or 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.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Garrett*

06855

168-2

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*161*

Village or City

*Friendsville*

(No. \_\_\_\_\_)

St.;

Ward)

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

2 FULL NAME

*John Wesley Van Sickle*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH *July 20, 1919*  
(Month) (Day) (Year)

7 AGE *2 yrs. 25 mos. 25 ds.* if LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ mo. ?

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 (State or country) *Garrett Co. Md*

## PARENTS

10 NAME OF FATHER *Samuel Vansichel*

11 BIRTHPLACE OF FATHER (State or country) *Garrett Co. Md*

12 MAIDEN NAME OF MOTHER *Ellie Uphole*

13 BIRTHPLACE OF MOTHER (State or country) *Garrett Co. Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Samuel Vansichel*

(Address)

*Friendsville Md RFD*

15

Filed

*5/17*

1919

*J. H. G. G. G.*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 18, 1919*  
(Month) (Day) (Year)

17 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, at..... m.

The CAUSE OF DEATH \* was as follows:

*No doctor in attendance*Contributory *Accidental death*  
Secondary*Smothered* (Duration)..... yrs..... mo..... ds.(Signed) *H. J. Mason* M. D.*191* (Address) *Friendsville Md*

\*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..... mo..... ds. In the State,..... yrs..... mo..... ds.

Where was disease contracted,

If not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Blooming Rose**May 17, 1919*

20 UNDERTAKER

ADDRESS

*M. W. Savage**Friendsville*

# 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 *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Cart 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. An example: (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*, *Homemaker*, 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"); *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menis-*

*es*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Wandering nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 da.*, *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATH state cause or 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*, *Reverber wound of head—homicide*, *Poisoned by carbonic 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.)

If this certificate is taken over thoroughly and all questions answered in detail, death prevent further correspondence. All the data is essential and must be obtained before the certificate permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

## PLACE OF DEATH

County

*Garrett*

06856

79

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

170

Village or City

*Weir Farm near Lonaconing*

(No.)

St.; Ward)

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

FULL NAME

*Mrs Ann Weir*

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

COLOR OR RACE

*White*SINGLE MARRIED, WIDOWED OR DIVORCED  
(Write the word)*Widowed*

DATE OF BIRTH

*August 23*

(Month)

(Day)

(Year)

AGE

*73*

yrs.

*8*

mos.

*26*

ds.

IF LESS than  
1 day, hrs.  
OR min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

*Housework*

(b) General nature of industry business, or establishment in which employed (or employer)

*Farm house*

BIRTHPLACE

(State or country)

*M<sup>+</sup> Ravala Maryland*

NAME OF FATHER

*Hugh McMillon*

BIRTHPLACE OF FATHER

(State or country)

*Scottland*

MAIDEN NAME OF MOTHER

*Margaret Smith*

BIRTHPLACE OF MOTHER

(State or country)

*South America*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*James Weir*

(Address)

*Lonaconing*

Filed

*May 21*, 1919*Geo B Broxer*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

*May 19*, 1919

(Month)

(Day)

(Year)

HEREBY CERTIFY, That I attended deceased from

*April 12*, 1919, to *May 19*, 1919.that I last saw her alive on *May 15*, 1919.and that death occurred on the date stated above, at *6 P.* m.

The CAUSE OF DEATH \* was as follows:

*Valvular disease Heart**5 Weeks - probably much longer*

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

*James O. Bullock*

M. D.

*May 20*, 1919. (Address)*Lonaconing*

\* 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

in the

of death

yrs.

mos.

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

*Philos Cemetery Westernport May 22*, 1919

UNDERTAKER

ADDRESS

*M Eickhorn Lonaconing*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

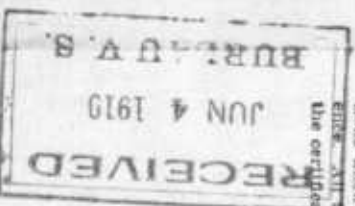
[Approved by U. S. Census and American Public Health  
Association.]

**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 whatsoever, 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*, *Pneumocystis* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *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," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "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.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARG RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH  
 County Garrett 06857 (45) STATE OF MARYLAND  
 169  
 CERTIFICATE OF DEATH  
 160  
 Registration Dist. No. \_\_\_\_\_  
 Village or City Smelter (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward \_\_\_\_\_  
 2 FULL NAME Pearl Hill [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED OR DIVORCED <u>Married</u> (Write the word)	16 DATE OF DEATH <u>May 12</u> , 191 <u>9</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>July 14</u> , 188 <u>9</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____	
7 AGE <u>30</u> yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?			that I last saw him _____ alive on _____, 191____	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Home duties</u> (b) General nature of industry, business, or establishment in which employed (or employer)			and that death occurred on the date stated above, at <u>12</u> m	
9 BIRTHPLACE (State or country) <u>Garrett Co</u>			The CAUSE OF DEATH * was as follows: <u>Melanoma</u> <u>of right iliac region, thigh, and</u> <u>internal. Primary in right groin.</u> Contributory _____ Secondary _____ (Duration) _____ yrs. mos. ds.	
PARENTS	10 NAME OF FATHER <u>Allen Hill</u>	(Signed) <u>Jas. A. McPherson</u> M. D.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Garrett Co</u>	<u>myself</u> , 191 <u>9</u> (Address) <u>Princeton Co</u>		
	12 MAIDEN NAME OF MOTHER <u>Rose Ann Brantley</u>	* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
13 BIRTHPLACE OF MOTHER (State or country) <u>Garrett Co</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>J. R. Murphy</u> (Address) <u>Smelter</u>			Where was disease contracted, If not at place of death? _____ Former or usual residence _____	
15 FILED <u>May 14</u> , 191 <u>9</u> <u>Wm. C. Peckham</u> REGISTRAR			19 PLACE OF BURIAL OR REMOVAL <u>Dry Run, Garrett Co</u> DATE OF BURIAL <u>May 14</u> , 191 <u>9</u>	
			20 UNDERTAKER <u>W. H. Hill Co</u> ADDRESS <u>Princeton Co</u>	



Name  
in Full

August Knofler

CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

Died at Belair Town Harford County MARYLAND

Date of death 1940 Year May Month 6 Day Age 76 Years — Months — Days

Sex Male Color or Race White Birth-place Saxony, Germany  
Amstedberg

Occupation Shoe Maker Where Residing if not at place of death Belair, Md.

Married, Single or Widowed Widowed Name of Wife or Husband —

Father's Name Godfrey Knofler Father's Birthplace Saxony, Germany

Mother's Maiden Name Mary Helmer Mother's Birthplace Saxony Germany

Name of person giving information Amelia H. Osheim How related to deceased Daughter

CAUSES OF DEATH

(40) ✓

Primary Cancer on a of the Stomach How long about a year or better

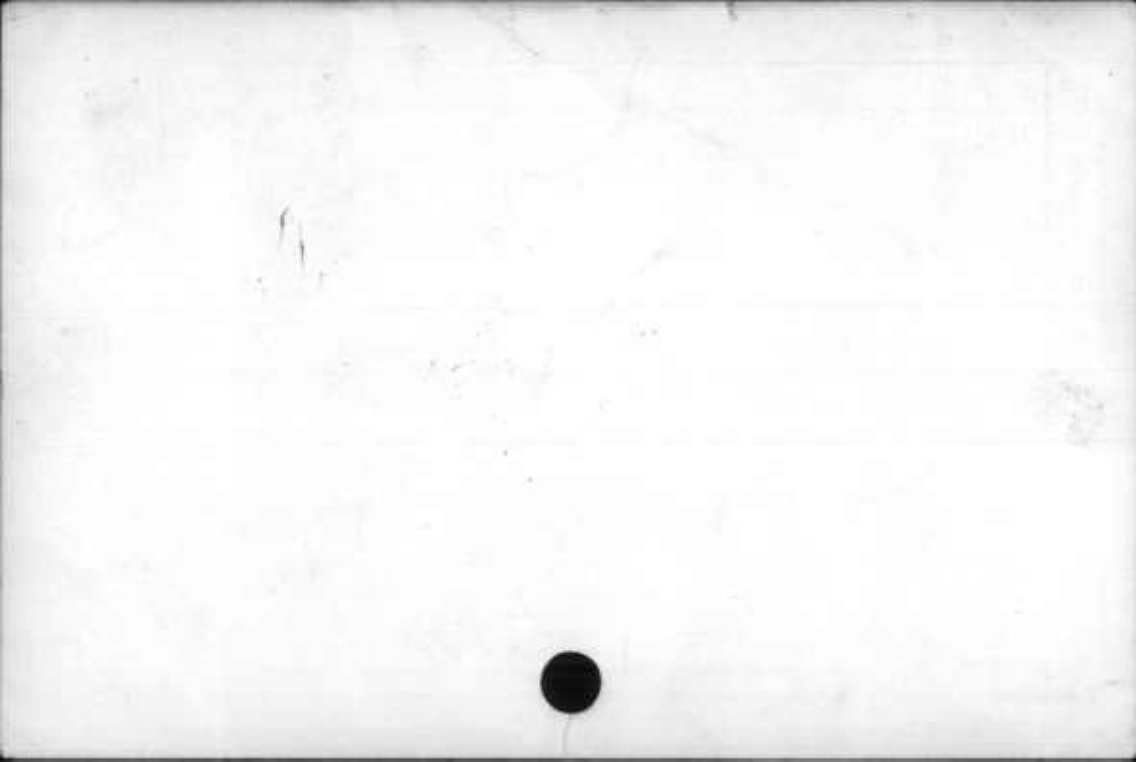
Immediate — How long —

PHYSICIAN  
OR CORONER

Are the name, age, sex, color, date and place correctly given above? yes

Signature of Physician William J. Archer

Address Bel Air - Md



Name in Full

*Maria Louisa Lyon*

CERTIFICATE OF DEATH

TO BE ANSWERED BY NEAREST FRIEND



Died at *Hare de Trace* Town *Harford* County **MARYLAND**

Date of death **190** *May 21* Month *21* Day *70* Age *70* Years Months Days

Sex *Female* Color or Race *White* Birth-place

Occupation *House work* Where Residing if not at place of death

Married,  Single  Widowed Name of Wife or Husband *M. Taylor Lyon*

Father's Name *Wm. Carly Pennington* Father's Birthplace *England.*

Mother's Maiden Name *Elija Ann Coale* Mother's Birthplace *Md.*

Name of person giving Information *Wm. T. Pennington* How related to deceased *Nephew*

CAUSES OF DEATH

190

Primary *Chronic Bronchitis* How long *2 yrs*

Immediate *Heart Weakness* How long *short time*

Are the name, age, sex, color, date and place correctly given above? *yes*

Signature of Physician *R. W. Smith*

Address *Hare de Trace Md*

PHYSICIAN OR CORONER

Accident or Suicide









Name  
in  
Full

Sallie Peaco

CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

Died at <u>Garland</u> <small>Town</small>		<u>Harford</u> <small>County</small>		MARYLAND	
Date of death <u>1980</u>	<u>May</u> <small>Month</small>	<u>6</u> <small>Day</small>	Age <u>37</u> <small>Years</small>	<u>—</u> <small>Months</small>	<u>—</u> <small>Days</small>
Sex <u>Female</u>	Color or Race <u>Col</u>	Birth-place <u>Harford Co Md</u>			
Occupation <u>Housework</u>	Where Residing if not at place of death <u>Same</u>				
Married, Single or Widowed <u>Married</u>	Name of Wife or Husband <u>Jacob Peaco</u>				
Father's Name <u>Wm J Smith</u>	Father's Birthplace <u>Harford Co Md</u>				
Mother's Maiden Name <u>Matilda Dorsey</u>	Mother's Birthplace <u>" "</u>				
Name of person giving Information <u>—</u>	How related to deceased <u>—</u>				

## CAUSES OF DEATH

Primary <u>Pleurisy</u>	How long <u>6 days</u>
Immediate <u>Pericarditis</u>	How long <u>2 days</u>
Are the name, age, sex, color, date and place correctly given above?	Signature of Physician <u>J. L. Hopkins</u>

Address

Harve de Grace  
MdPHYSICIAN  
OR CORONER

Accident or Suicide



Name  
in Full

Elijah Piper = Piper

CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

MARYLAND

Died at Emmorton <sup>Town</sup> Harford <sup>County</sup>

Date of death 1960 <sup>Month</sup> May <sup>Day</sup> 26 <sup>Years</sup> 84 <sup>Months</sup> 2 <sup>Days</sup> —

Sex Female Color or Race White Birth-place Germany

Occupation Wife Where Residing If not at place of death Emmorton Ind.

Married, Single or Widowed Widowed Name of Wife or Husband —

Father's Name Unknown Father's Birthplace Unknown

Mother's Maiden Name Unknown Mother's Birthplace Unknown

Name of person giving Information Bertha Piper How related to deceased Daughter-in-law

## CAUSES OF DEATH

Primary Coronial haemorrhage How long 6 weeks

Immediate Exhaustion How long —

Are the name, age, sex, color, date and place correctly given above?

Signature of Physician

Robert S. Poy

Address

Bel Air

Accident or Suicide



Name  
in  
Full

Patrick, J. Shanahan

CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

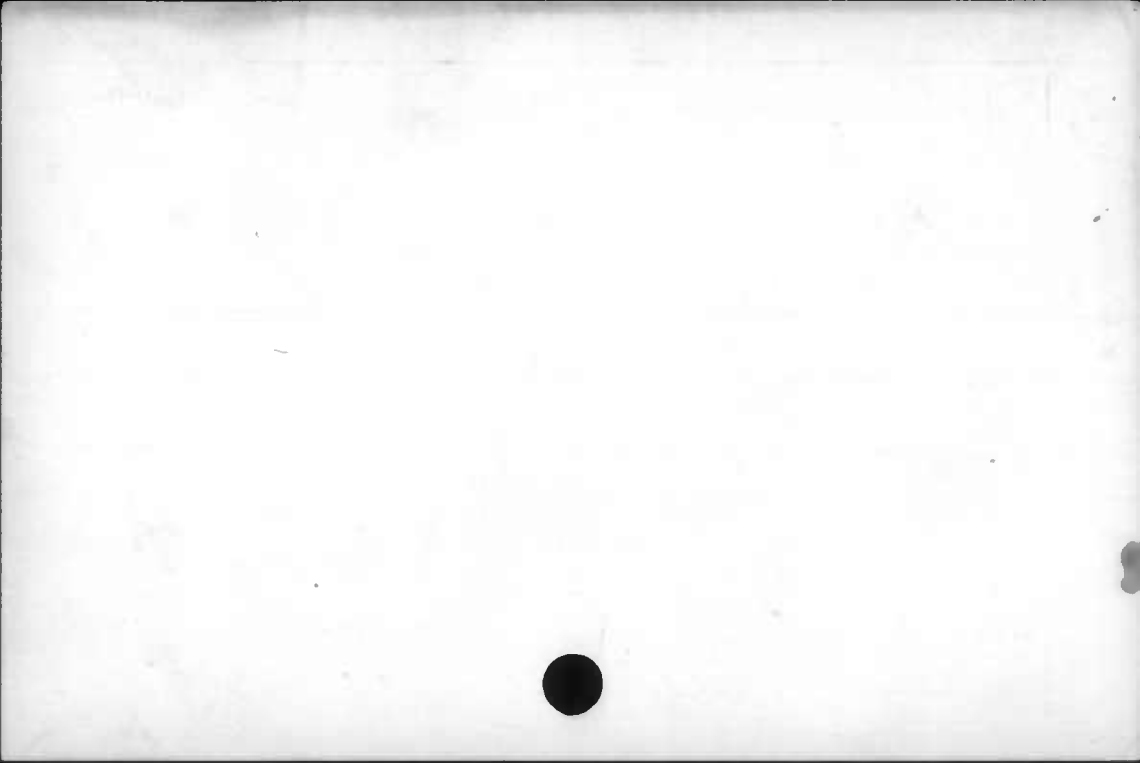
Died at <i>Fallston</i> <small>Town</small>		<i>Harford</i> <small>County</small>		MARYLAND	
Date of death <i>1900</i>		Month <i>May</i>	Day <i>28</i>	Age <i>53</i>	Months <i>—</i>
Sex <i>Male</i>	Color or Race <i>White</i>	Birth-place <i>Harford Co.,</i>			
Occupation <i>Farmer</i>		Where Residing if not at place of death			
Married, Single or Widowed <i>Married</i>	Name of Wife or Husband <i>Anne, E. Shanahan</i>				
Father's Name <i>John, M. Shanahan</i>		Father's Birthplace <i>Ireland</i>			
Mother's Maiden Name <i>Catherine Kennedy</i>		Mother's Birthplace <i>Ireland</i>			
Name of person giving Information <i>D. J. Shanahan</i>		How related to deceased <i>Brother</i>			

## CAUSES OF DEATH

Primary <i>Cancer of Stomach</i>	How long <i>about 18 months</i>
Immediate	How long
Are the name, age, sex, color, date and place correctly given above? <i>Yes</i>	Signature of Physician <i>William A. Arche</i>
	Address <i>Belt Ave Md</i>

PHYSICIAN  
OR CORONER

Accident or Suicide



Name  
in  
Full

Amber C. Bills

CERTIFICATE OF DEATH

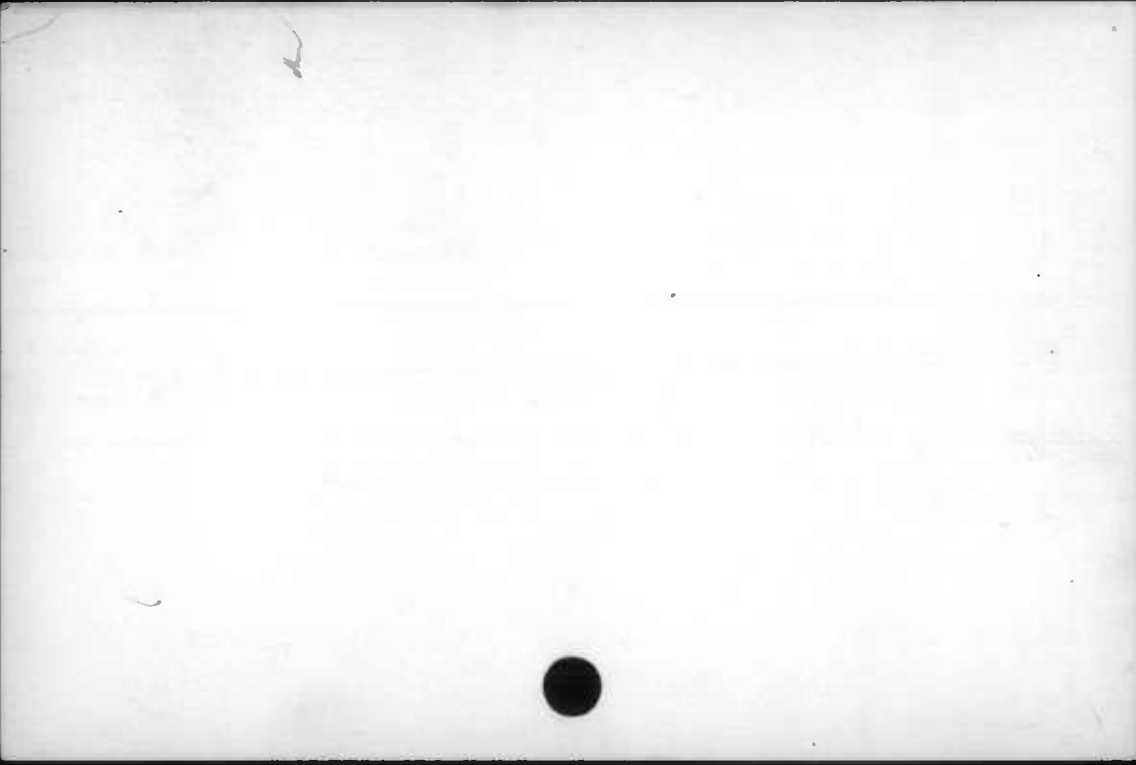
TO BE ANSWERED BY  
NEAREST FRIEND

✓

Died at		Town Harreds Grace		County Harford.		MARYLAND	
Date of death	196	Month May	Day 21	Age	28	Months	Days
Sex	Female	Color or Race	White		Birth-place	Harreds Grace	
Occupation	House work		Where Residing if not at place of death				
Married, Single or Widowed	Married		Name of <del>Wife</del> Husband Jacob Sills				
Father's Name	Samuel Botts				Father's Birthplace	Harford Co.	
Mother's Maiden Name	Mary C. Taylor				Mother's Birthplace	Harford Co.	
Name of person giving information	Jacob Sills				How related to deceased	Husband.	

## CAUSES OF DEATH

PHYSICIAN OR CORONER	Primary	Eclampsia	How long	20 days
	Immediate	Cardiac ailment	How long	7 hours
	Are the name, age, sex, color, date and place correctly given above?	Yes	Signature of Physician	J. N. Steiner
Address		Harreds Grace Md		
I Accident or Suicide				





Name  
in  
Full

No name (Still Born)

CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

✓

MARYLAND

Died at Har de Gure <sup>Town</sup> Harford <sup>County</sup>

Date of death 1940 <sup>Month</sup> May <sup>Day</sup> 21 <sup>Age</sup> foetus <sup>Years</sup>          <sup>Months</sup>          <sup>Days</sup>         

Sex Male Color or Race white Birth-place Har de Gure

Occupation None Where Residing if not at place of death at place of death

~~Married~~ <sup>Single</sup> Name of Wfs or Husband None

Father's Name Jacob Pills Father's Birthplace md

Mother's Maiden Name Alvina Botts Mother's Birthplace md

Name of person giving Information Jacob Pills How related to deceased Father

CAUSES OF DEATH

(5)

Primary Cause unknown How long not know

Immediate urmic autotoxication How long not know

Are the name, age, sex, color, date and place correctly given above? yes Signature of Physician J. W. Steiner

Address Har de Gure

Accident or Suicide md

PHYSICIAN  
OR CORNER



Name in Full

Mary L. Simpson.

CERTIFICATE OF DEATH

TO BE ANSWERED BY NEAREST FRIEND

MARYLAND

Died at *Hardegrave* Town *Harford* County

Date of death 19*0* *May* Month *30<sup>th</sup>* Day Age *69* Years Months *4* Days *—*

Sex *Female* Color or Race *White* Birth-place *Cecil Co.*

Occupation *Housework* Where Residing if not at place of death *Hardegrave*

Married—Single or Widowed *Widowed* Name of ~~Wife~~ Husband *John J. Simpson*

Father's Name *Edward Hyland* Father's Birthplace *Cecil Co.*

Mother's Maiden Name *Mary L. Clarke* Mother's Birthplace *Ireland*

Name of person giving Information *Bertie Simpson* How related to deceased *Daughter*

CAUSES OF DEATH

79

Primary *Valvular Heart d* How long *1 year*

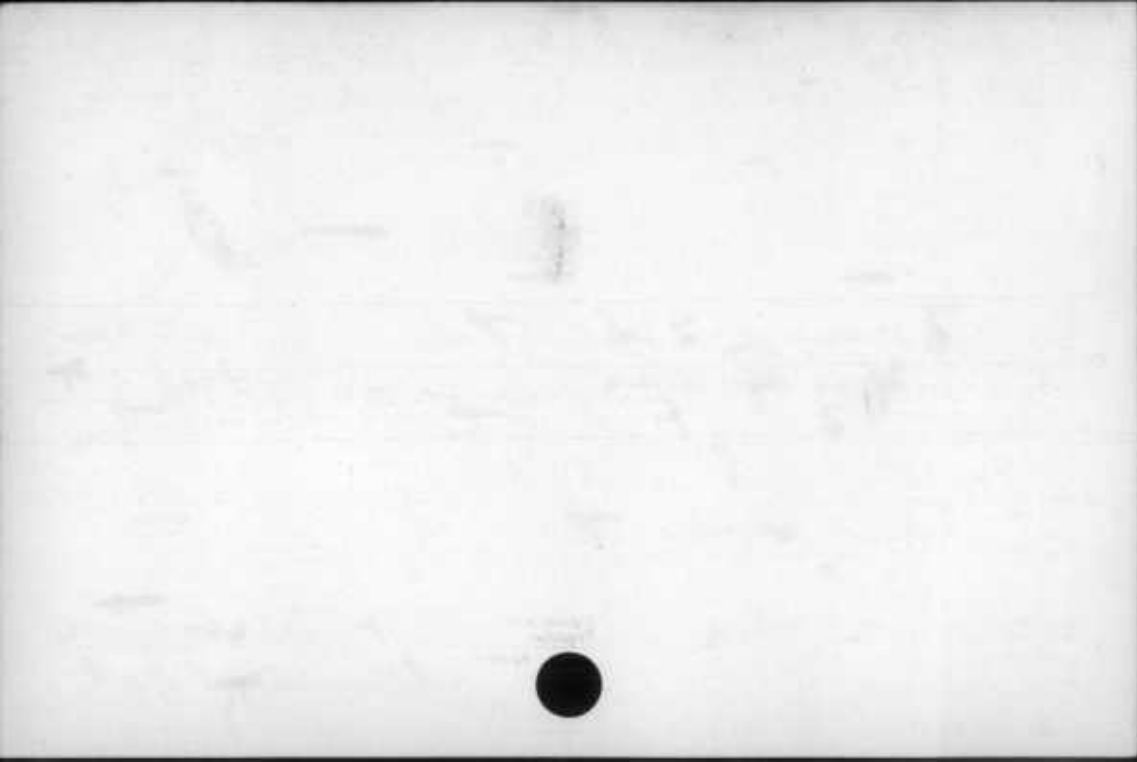
Immediate *a*

Are the name, age, sex, color, date and place correctly given above? *Yes*

Signature of Physician *A. C. Goheen* Address *Hardegrave*

PHYSICIAN OR CORONER

Accident or Suicide



Infant Smithson

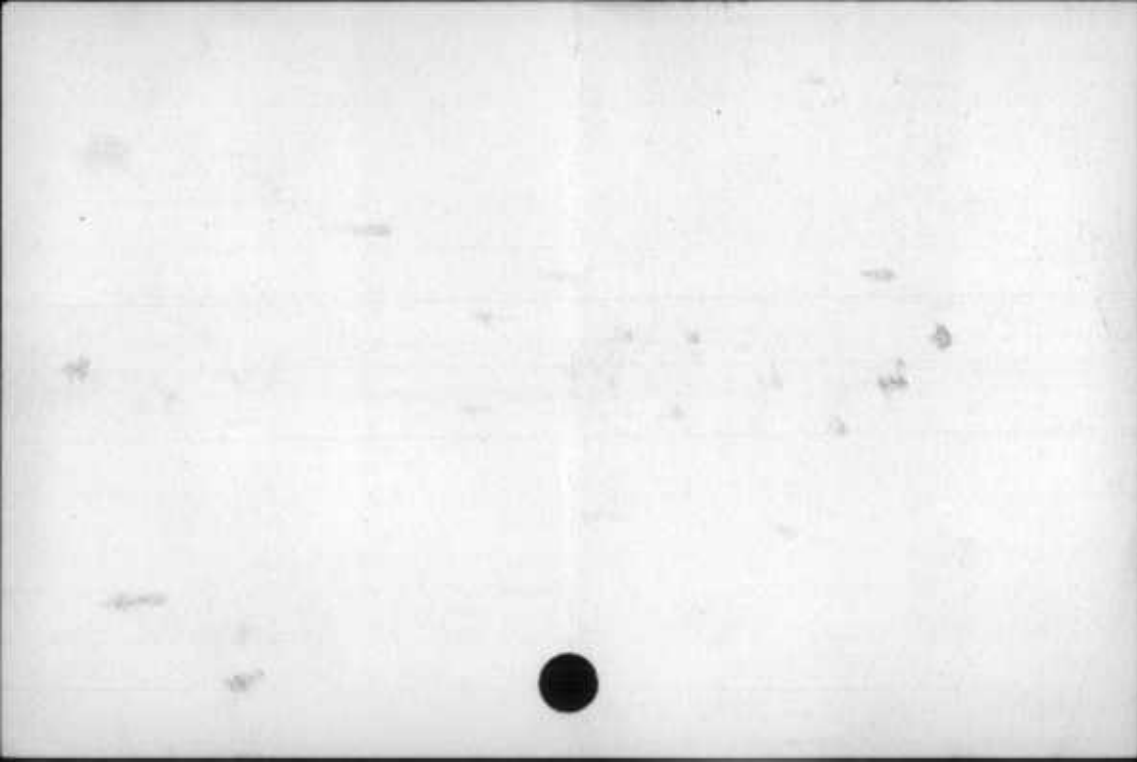
TO BE ANSWERED BY  
NEAREST FRIEND

Died at <u>Whiteford</u> <sup>Town</sup>		<u>Harford</u> <sup>County</sup>		MARYLAND	
Date of death <u>1900</u>	<u>May</u> <sup>Month</sup>	<u>24</u> <sup>Day</sup>	Age <u>—</u> <sup>Years</sup>	<u>—</u> <sup>Months</sup>	<u>—</u> <sup>Days</sup>
Sex <u>Female</u>	Color or Race <u>white</u>		Birthplace <u>Whiteford</u>		
Occupation: <u>—</u>			Where Reared if not at place of death: <u>—</u>		
Married, Single or Widowed: <u>—</u>		Name of Wife or Husband: <u>—</u>			
Father's Name <u>Emory Z. Smithson</u>			Father's Birthplace <u>Betta Pa</u>		
Mother's Maiden Name <u>Miss Grapes</u>			Mother's Birthplace <u>Harford Co</u>		
Name of person giving information <u>Emory H. Smithson</u>			How related to deceased <u>Father</u>		

## CAUSES OF DEATH

PHYSICIAN  
OR CORONER

Primary <u>born at birth</u>	How long <u>—</u>
Immediate <u>" "</u>	How long <u>—</u>
Are the name, age, sex, color, date and place correctly given above? <u>Yes</u>	Signature of Physician <u>D. W. E. Arthur</u>
	Address <u>Seardoff Md</u>
Accident or Suicide? <u>No</u>	



Name in Full

CERTIFICATE OF DEATH

TO BE ANSWERED BY NEAREST FRIEND

James B. Snodgrass

Town *Harreds Grace* County *Harford*

MARYLAND

Date of death 19*60* Month *May* Day *29<sup>th</sup>* Age *60* - Months - Days -

Sex *Male* Color or Race *White* Birthplace *Lancaster Co. Pa.*

Occupation *Slater* Where Residing if not at place of death *Harreds Grace*

Married, Single or Widowed *Married* Name of Wife or ~~husband~~ *Emma Snodgrass*

Father's Name *Robert Snodgrass* Father's Birthplace *Lancaster Co. Pa.*

Mother's Maiden Name *Rachel Blackburn* Mother's Birthplace *Chester Co. Pa.*

Name of person giving information *Emma Snodgrass* How related to Deceased *Wife*

CAUSES OF DEATH

*143* ✓

Primary *Carcinoma of Bladder* How long *6 mo*

Immediate *Hemorrhages* How long *3 or 4 weeks*

Are the name, age, sex, color, date and place correctly given above? *Yes*

Signature of Physician *J. L. Hopkins*

Address *Harreds Grace Md*

PHYSICIAN OR CORONER

Accident or Suicide





Name  
in  
Full

John O. Stearns

## CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

Died at Whitford County Harford. MARYLAND

Date of death 1960 May 26 Age 71 Years 5 Months  Days

Sex Male. Color or Race White Birth-place Ind

Occupation Justice of Peace Where Residing if not at place of death

Married Yes Name of Wife or Husband Ellen Stearns

Father's Name John S. Stearns Father's Birthplace Not Known

Mother's Maiden Name Mary A. Gibbons Mother's Birthplace " "

Name of person giving information W. G. Stearns How related to deceased Son

## CAUSES OF DEATH

Primary Mixed degeneration How long 2 yr

Immediate Paralysis How long 10 days

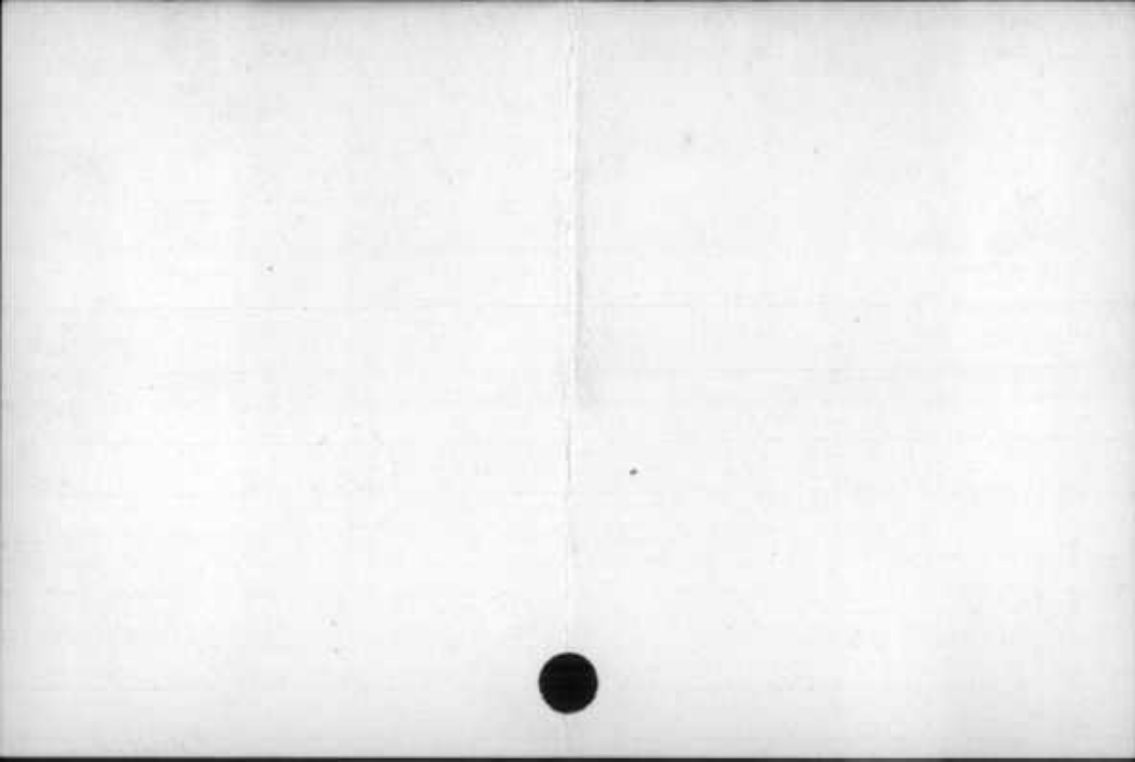
Are the name, age, sex, color, date and place correctly given above? yes

Signature of Physician Rudener Ranney

Address Delia Penna

Accident or Suicide?

PHYSICIAN  
OR CORONER



Adda W. Stephens

CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

Died at <i>Whitford</i> <small>Town</small>		<i>Hopford</i> <small>County</small>		MARYLAND	
Date of death	<i>1930</i> <small>Year</small>	<i>May</i> <small>Month</small>	<i>22</i> <small>Day</small>	Age <i>28</i> <small>Years</small>	<i>2</i> <small>Months</small>
Sex <i>Female</i>	Color or Race <i>White</i>	Birth-place <i>Pa</i>		Occupation <i>House wife</i>	
Married or Widowed <input checked="" type="checkbox"/>	Name of Wife or Husband <i>Archie Stephens</i>				
Father's Name <i>W. Fantom</i>	Father's Birthplace <i>Not known</i>		Mother's Maiden Name <i>Catherine Wise</i>		
Mother's Birthplace <i>Pa</i>		Name of person giving information <i>Archie Stephens</i>			
How related to deceased <i>Husband</i>		Where Residing if not at place of death _____			

CAUSES OF DEATH

*137* ✓  
How long *Long days*  
How long \_\_\_\_\_

PHYSICIAN  
OR CORONER

Primary <i>Coronary Arteriosclerosis</i>	Signature of Physician <i>D. H. E. Arthur</i>
Immediate <i>" "</i>	Address <i>Cardiff Md</i>
Are the name, age, sex, color, date and place correctly given above? <input checked="" type="checkbox"/>	Accident or Suicide? <input checked="" type="checkbox"/>

Guthrie

Name  
in  
Full

CERTIFICATE OF DEATH

TO BE ANSWERED BY  
NEAREST FRIEND

John O Sullivan  
Town

County

Died at Bel Camp

Harford Co.

MARYLAND

Date of death 1960 May

Day 17 Tuesday

Age 73

Months

Days

Sex Male

Color or Race White

Birth place Kerry Co. Ireland

Occupation Farmer

Where Residing if not at place of death

Married, Single or Widowed Widowed

Name of Wife or Husband Mary Sullivan

Father's Name Michael Sullivan

Father's Birthplace Kerry Ireland

Mother's Maiden Name Johannah Lynch

Mother's Birthplace Kerry Ireland

Name of person giving information Jerry J Sullivan

How related to deceased Son

CAUSES OF DEATH

120

Primary Chronic Brights disease

How long 3 years

Immediate ifhaustic

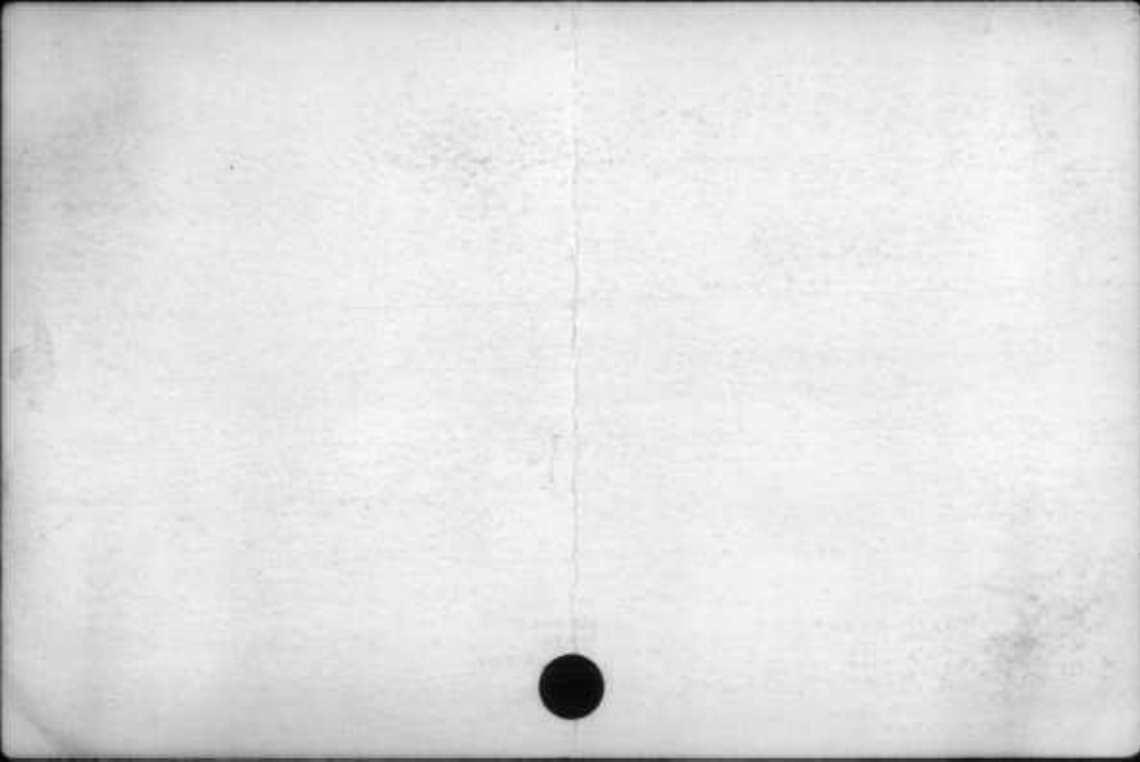
How long 3 weeks

Are the name, age, sex, color, date and place correctly given above? yes

Signature of Physician J.A. Callahan  
Address Belcamp, R.F.D. #1 Maryland

PHYSICIAN OR CORONER

Accident or Suicide No



Name  
In Full

Armus Thompson


CERTIFICATE OF DEATH

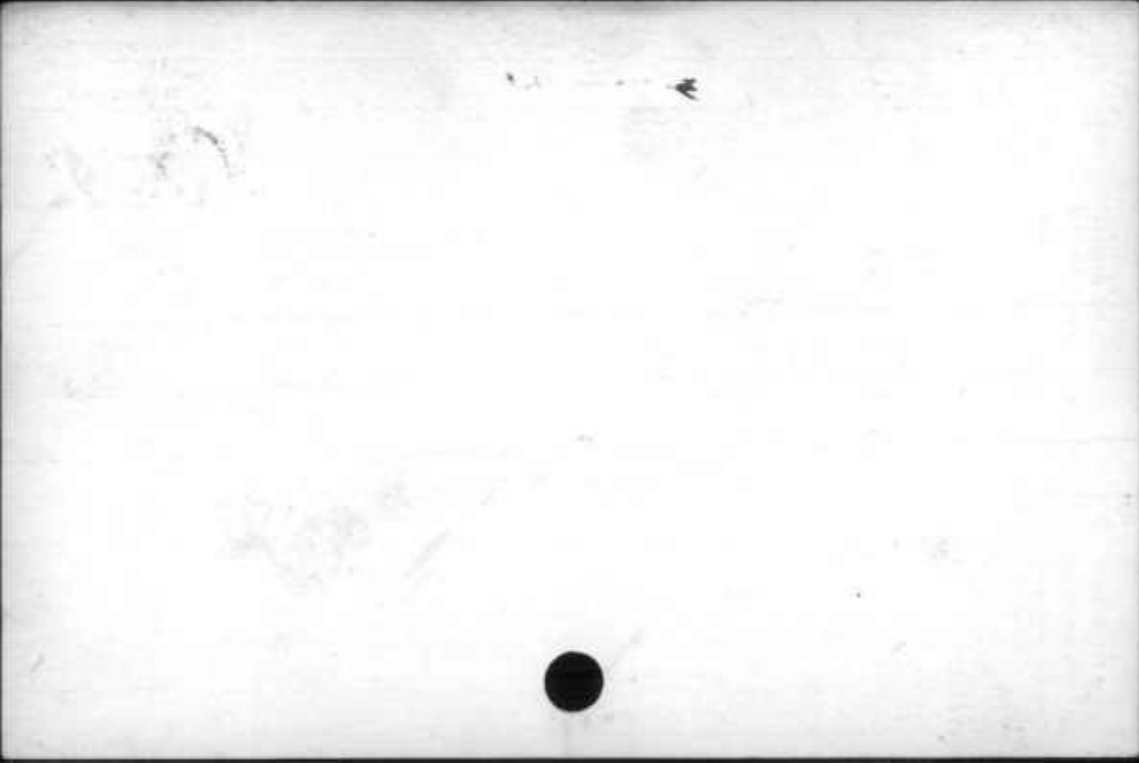
TO BE ANSWERED BY  
NEAREST FRIENDDied at <sup>Town</sup> Robin Hood <sup>County</sup> Herford MARYLANDDate of death 1960 <sup>Month</sup> May <sup>Day</sup> 8 Age <sup>Years</sup> 62 <sup>Months</sup> <sup>Days</sup>Sex male <sup>Color or Face</sup> White <sup>Birthplace</sup> Robin HoodOccupation <sup>Where Residing if not at place of death</sup> Canner Robin HoodMarried, ~~Single~~ <sup>Name of Wife or Husband</sup>Father's Name <sup>Father's Birthplace</sup> Olifa ThompsonMother's Maiden Name <sup>Mother's Birthplace</sup> Martha HorcyakName of person giving Information <sup>How related to deceased</sup> Wife

## CAUSES OF DEATH

Primary <sup>How long</sup> Angina Pectoris About 1 YrImmediate <sup>How long</sup> Heart ComplicationAre the name, age, sex, color, date and place correctly given above?  Yes

Signature of Physician R W Truickhead

Address  Youngs de Good roadAccident or Suicide PHYSICIAN  
OR CORONER





Name in Full

Not named Wright

CERTIFICATE OF DEATH

TO BE ANSWERED BY NEAREST FRIEND

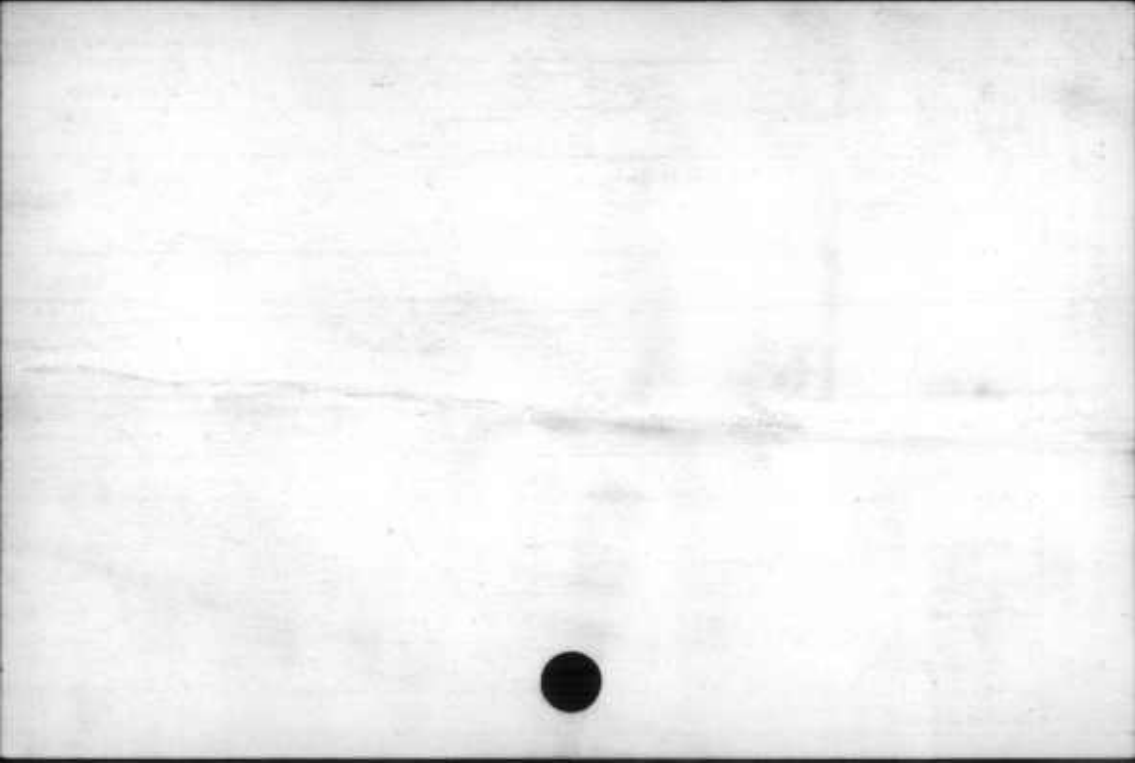
MARYLAND

Died at <u>New Auburn</u> Town		<u>Harford</u> County			
Date of death <u>1990</u>	Month <u>May</u>	Day <u>1</u>	Age <u>0</u>	Years <u>0</u>	Months <u>0</u>
Sex <u>Male</u>	Color or Race <u>Colored</u>	Birthplace <u>New Auburn</u>			
Occupation <u>None</u>	Where Residing if not at place of death _____				
Married, Single or Widowed <u>single</u>	Name of Wife or Husband _____				
Father's Name <u>Wm Wright</u>	Father's Birthplace <u>Pa</u>				
Mother's Maiden Name <u>Lizzie Pitt</u>	Mother's Birthplace <u>Harford Co Md</u>				
Name of person giving Information <u>Tom Wright</u>	How related to deceased <u>Father</u>				

CAUSES OF DEATH

PHYSICIAN OR CORONER

Primary	<u>Still born</u>	How long	<u>                    </u>
Immediate		How long	<u>                    </u>
Are the name, age, sex, color, date and place correctly given above?	<u>Yes</u>	Signature of Physician	<u>Chas H. White</u>
		Address	<u>Auburn</u>
Accident or Suicide	<u>                    </u>		<u>                    </u>



TO BE ANSWERED BY  
NEAREST FRIEND

Died at <i>Sevel</i> <small>Town</small> <i>Young</i> <small>County</small>		MARYLAND			
Date of death	<i>1910</i>	Month <i>May</i>	Day <i>27</i>	Age <i>None</i>	Months <i>none</i> Days <i>1</i>
Sex <i>Female</i>	Color or Race <i>White</i>		Birth place <i>Sevel Md</i>		
Occupation <i>None</i>	Where Residing if not at place of death <i>at Place of Death</i>				
Married, Single or Widowed <i>Single</i>	Name of Wife or Husband <i>None</i>				
Father's Name <i>William A Young</i>	Father's Birthplace <i>Hamdr Md</i>				
Mother's Maiden Name <i>Gertrude S Sheridan</i>	Mother's Birthplace <i>Steffy Md</i>				
Name of person giving in formation <i>William A Young</i>	How related to deceased <i>Father</i>				

## CAUSES OF DEATH

PHYSICIAN OR CORONER	Primary <i>Atelactis</i>	How long <i>1 day</i>	
	Immediate <i>Asphyxia</i>	How long <i>4 hours</i>	
	Are the name, age, sex, color, date and place correctly given above? <i>Yes</i>	Signature of Physician <i>F. H. Steiner</i>	
		Address <i>Hamdr Md</i>	
Accident or Suicide? <i>H</i>			

