

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Monroe
Township Union Registration District No. 580 File No. 31331
Village _____ Primary Registration District No. 5792 Registered No. 19
City _____ (NO. 5797 St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME George Washington Armstrong

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Widow WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH June 13, 1846
(Month) (Day) (Year)
AGE 64 yrs. 4 mos. 1 ds. IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) Teaching
BIRTHPLACE (City or town, State or foreign country) Illinois
PARENTS
NAME OF FATHER John Armstrong
BIRTHPLACE OF FATHER (City or town, State or foreign country) Illinois
MAIDEN NAME OF MOTHER Mary Board
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 14, 1910
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Oct 9, 1910, to Oct 14, 1910, that I last saw him alive on Oct 14, 1910, and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Pharyngitis
109A
130
(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Acute Bright's (SECONDARY) Waste (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) E. W. Johnson M. D.
Oct 15, 1910 (Address) Osage Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. G. W. Armstrong
(ADDRESS) Caloach Mo.
Filed Oct. 17th, 1910. E. C. Brooks
REGISTRAR

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____
PLACE OF BURIAL OR REMOVAL Pleasant Grove DATE OF BURIAL Oct 16, 1910
UNDERTAKER W. S. Bush ADDRESS Central Mo.

Revised United States Standard Certificate of Death

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

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Can less definite; avoid use of "Tumor" for ma neoplasms); *Measles*; *Whooping cough*; *Chronic lar heart disease*; *Chronic interstitial nephritis*, et contributory (secondary or intercurrent) affectio not be stated unless important. Example: *Meas ease causing death*, 29 ds.; *Bronchopneumon ondary*, 10 ds. Never report mere symptoms, mingal conditions, such as "Asthenia," "At (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," "Dropsy," "Exhaustion," "Heart failure," "I rhage," "Inanition," "Marasmus," "Old age," "Uraemia," "Weakness," etc., when a definite can be ascertained as the cause. Always qu diseases resulting from childbirth or miscarr "PUERPERAL septichaemia," "PUERPERAL peritoni 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.)

