

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 Jerry
 Township St. Marys Registration District No. 663 File No. 35160
 or
 Village ✓ Primary Registration District No. 5881 Registered No. 9
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Dollie Duvall

PERSONAL AND STATISTICAL PARTICULARS

SEX Female **COLOR OR RACE** Caucasian **SINGLE MARRIED WIDOWED OR DIVORCED** (Write the word)
DATE OF BIRTH Aug 17, 1884
 (Month) (Day) (Year)
AGE 26 yrs. 3 mos. — ds. **IF LESS than 1 day, ___ hrs. or ___ min.?**

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

BIRTHPLACE
 (City or town, State or foreign country) Jerry co. mo

PARENTS
NAME OF FATHER John Duvall
BIRTHPLACE OF FATHER (City or town, State or foreign country) Jerry co. mo
MAIDEN NAME OF MOTHER Mary Porter
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jerry co. mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Duvall
 (ADDRESS) Salon Lake, Mo.

Filed Nov 18 1910 Dr. G. A. [Signature]
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH. Nov 17, 1910
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 16, 1910, to Nov 17, 1910, that I last saw her alive on Nov 16, 1910, and that death occurred, on the date stated above, at 9 a.m.
 The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 yrs. 6 mos. — ds.
Contributory
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ M. D.
 _____, 1910 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Salon Lake
DATE OF BURIAL Nov 18 1910
UNDERTAKER none
ADDRESS none

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, peritonaeum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "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.)



County Cerry Registration District No. 663 File No. 35160
 Township St. Marys Primary Registration District No. 5881 Registered No. 9
 or
 Village _____ City _____ (NO. _____ St.: _____ Ward)

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

FULL NAME Dollie Duwall

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>Caucasian</u>	SINGLE MARRIED WIDOWED OR DIVORCED <i>(Write the word)</i> <u>Single</u>
DATE OF BIRTH <u>Aug. 17, 1884</u> (Month) (Day) (Year)		
AGE <u>26 yrs. 3 mos. - ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Factory girl</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Shoe Manufacturer</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Cerry Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>John Duwall</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Cerry Co. Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Mary Jones</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Cerry Co. Mo.</u>	

DATE OF DEATH Nov. 17, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 15, 1910, to Nov. 17, 1910, that I last saw her alive on Nov 16, 1910, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) _____ yrs. 6 mos. _____ ds.

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

(Signed) Dr. Geo. A. Blalock M.D.
Nov 17, 1910 (Address) Bellevue Mo.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted
If not at place of death?

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Duwall
(ADDRESS) Selva, Lake Mo
Filed Nov 17, 1910 Dr. Geo. A. Blalock REGISTRAR

PLACE OF BURIAL OR REMOVAL Selva Lake Mo DATE OF BURIAL Nov. 18, 1910
 UNDERTAKER None ADDRESS None

Revised United States Standard Certificate of Death

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

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coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)