

IS A PERMANENT RECORD

WRITE PLAINLY

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.

## PLACE OF DEATH

County Jerry  
 Township St. Marys  
 or  
 Village L  
 or  
 City L (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

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

Registration District No. 668 File No. 35161  
 Primary Registration District No. 5881 Registered No. 10

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

## FULL NAME

Lurinda Mullins

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Caucasian SINGLE MARRIED married  
 WIDOWED OR DIVORCED (Write the word)

## DATE OF BIRTH

Good Monday 1849  
 (Month) (Day) (Year)

## AGE

63 yrs. — mos. — ds. If LESS than 1 day, 2 hrs. or — min.?

## OCCUPATION

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

## BIRTHPLACE

Yount Mo.  
 (City or town, State or foreign country)

## PARENTS

## NAME OF FATHER

Thomas Thompson

## BIRTHPLACE OF FATHER

North Galina  
 (City or town, State or foreign country)

## MAIDEN NAME OF MOTHER

Mary Thompson

## BIRTHPLACE OF MOTHER

North Galina  
 (City or town, State or foreign country)

## THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. W. Thompson

(ADDRESS) Higdon Ave

Filed Nov 28 1910.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## DATE OF DEATH

Nov 27, 1910  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 9/12, 1910, to 11/28, 1910, that I last saw her alive on Nov 25, 1910, and that death occurred, on the date stated above, at 10 a.m. The CAUSE OF DEATH\* was as follows:

Hemiplegia  
Age of heart

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ 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

Grave cemetery

## DATE OF BURIAL

Nov 28, 1910

## UNDERTAKER

None

## ADDRESS

L

# Revised United States Standard Certificate of Death

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

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

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

HUGH STEPHENS, JEFFERSON CITY.



N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH  
County Curry  
Township St. Marije  
or  
Village  
or  
City

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Registration District No. 663  
Primary Registration District No. 5881

File No. 35161  
Registered No. 10

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

FULL NAME Lorna Mullins

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>Caucasian</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u>
DATE OF BIRTH <u>Nov 11 1847</u> (Month) (Day) (Year)		
AGE <u>63</u> yrs. <u>—</u> mos. <u>—</u> ds.		If LESS than 1 day, <u>—</u> hrs. or <u>—</u> min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Yount Mo</u>		
PARENTS	NAME OF FATHER <u>Thomas Thompson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>North Colino</u>	
	MAIDEN NAME OF MOTHER <u>Mary Thompson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>North Colino</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 27, 1910  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from 9/12, 1910, to 11/23, 1910, that I last saw her alive on Nov 25, 1910, and that death occurred, on the date stated above, at 100 m.

The CAUSE OF DEATH\* was as follows:  
Emoplegia  
Emoplegia

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

(Signed) Dr. Geo. B. Blythe M. D.  
Nov 27 1910 (Address) Delaware Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Geo. W. Thompson  
(ADDRESS) Higdon Mo  
Filed Nov 27 1910 Dr. Geo. B. Blythe  
REGISTRAR

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  
Mon Cemetery

DATE OF BURIAL  
Nov. 28 1910

UNDERTAKER  
None

ADDRESS

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

# Revised United States Standard Certificate of Death

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

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