

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Nodaway

Township Green

Village Burkington Mo

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 628

File No. 39032

Primary Registration District No. 5880

Registered No. _____

FULL NAME Anna Bell Stafford

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Nov 23, 1910
(Month) (Day) (Year)

DATE OF BIRTH June 28, 1857
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 20, 1910, to Nov 23, 1910, that I last saw her alive on Nov 23, 1910, and that death occurred, on the date stated above, at 12 m.

AGE 52 yrs. 4 mos. 25 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH was as follows:
Paralysis
95 B
82 D

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

BIRTHPLACE (City or town, State or foreign country) Nodaway Iowa

PARENTS
NAME OF FATHER Thomas Thompson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa
MAIDEN NAME OF MOTHER Mary Finley
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

Contributory (SECONDARY) Heart trouble blood clot
(Duration) ___ yrs. ___ mos. 3 ds.
(Signed) W. Wallace M. D.
Nov 24, 1910 (Address) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Stafford
(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 8 yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

Filed Dec 8, 1910 H. W. Raymond REGISTRAR

PLACE OF BURIAL OR REMOVAL Ohio cemetery DATE OF BURIAL Nov 24, 1910
UNDERTAKER J. E. Forder ADDRESS Burkington Mo

RECORDS IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

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, 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 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.)



PHYSICIANS should state EXACTLY the cause of death. Exact statement of OCCUPATION is very important.

PLACE OF BIRTH

County Nodaway
 Township Gorwin
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
 RECEIVE A FEE FOR CERTIFICATES
 UNTIL THEY ARE COMPLETED AS
 PRESCRIBED BY LAW.

Registration District No. 628 File No. 39032
 Primary Registration District No. 5830 Registered No. _____

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

FULL NAME Anna Bell Stafford

PERSONAL AND STATISTICAL PARTICULARS

SEX Woman COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
 DATE OF BIRTH June 28, 1857
 (Month) (Day) (Year)
 AGE 52 yrs. 4 mos. 25 ds. If LESS than 1 day, _____ hrs. or _____ min.?
 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) Housewife

BIRTHPLACE (City or town, State or foreign country) Nodaway, Iowa
 NAME OF FATHER Thomas Thompson
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind.
 MAIDEN NAME OF MOTHER Mary S. Finley
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) George Stafford

(ADDRESS) Burlington Junction
 Filed Dec 8 - 1910 F. M. Ryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Nov 20, 1910, to Nov 23, 1910, that I last saw alive on Nov 23, 1910, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:
Paralysis.

(Duration) _____ yrs. _____ mos. 3 ds.
 Contributory Heart trouble - blood clot.
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) H. E. Wallace M. D.
Nov 24, 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.
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 At place of death 8 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 Ohio Cemetery DATE OF BURIAL Nov 24, 1910
 UNDERTAKER J. E. Fordyce ADDRESS Burlington Junction

DEC

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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