

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 Howell
 County Howell Registration District No. 385 File No. 1876
 Township Willow Springs or Willow Springs Primary Registration District No. 5536 Registered No. 8
 Village _____ or _____ City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Hazel Rose Morgan

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>May 15 1900</u> (Month) (Day) (Year)		
AGE <u>6 yrs. 8 mos. 4 ds.</u>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>0</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Near Willow Springs Mo</u>		
PARENTS	NAME OF FATHER <u>Jesse M Morgan</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Wis.</u>	
	MAIDEN NAME OF MOTHER <u>Emma Schenkel</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ireuske, Neb</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 19 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January 1 1911, to July 19 1911, that I last saw her alive on July 15 1911, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:
Scarlet Fever
g
 (Duration) ___ yrs. ___ mos. 19 ds.

Contributory (SECONDARY) _____
 (Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) J. C. Davis M. D.
1-19 1911 Address Willow Springs 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) Emma Schenkel
 (ADDRESS) Willow Springs Mo

PLACE OF BURIAL OR REMOVAL <u>Home Willow Springs</u>	DATE OF BURIAL <u>Jan 19 1911</u>
UNDERTAKER <u>Emma Schenkel</u>	ADDRESS <u>Willow Springs Mo</u>

Filed Jan 19 1911 J. P. Rome
 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*, *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 reference to time and causation), using always the same accepted term for the same disease. Examples: *Cerebral spinal fever* (the only definite synonym "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (fever reports "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia*; "pneumonia," unqualified, is indefinite; *Tuberculosis*, *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.)

HEALTH DEPARTMENT
 DIVISION OF VITAL STATISTICS
 BUREAU OF RECORDS AND STATISTICS
 WASHINGTON, D. C.

ADDRESS
 DATE OF BIRTH
 101

NAME OF DECEASED
 SEX
 AGE
 OCCUPATION
 PLACE OF BIRTH
 PLACE OF DEATH
 DATE OF DEATH
 TIME OF DEATH
 CAUSE OF DEATH
 CONTRIBUTORY CAUSES
 SIGNATURE OF PHYSICIAN
 SIGNATURE OF REGISTRAR
 PLACE AND DATE OF SIGNATURE

HUGH STEPHENSON, REGISTRAR
 WASHINGTON, D. C.