

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 Clark
Township Wyaconda
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 191 File No. 13783
Primary Registration District No. 5266 Registered No. 5

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

FULL NAME Miss Minnie Bell Dial

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Single</u>
DATE OF BIRTH <u>Oct 2nd 1895</u> (Month) (Day) (Year)		
AGE <u>15</u> yrs. <u>5</u> mos. <u>25</u> ds.		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work (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>Marys Fork Jefferson Co Tenn</u>		
PARENTS	NAME OF FATHER <u>Robt Murren Dial</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Marys Fork Jefferson Co Tenn</u>	
	MAIDEN NAME OF MOTHER <u>Julia Rife</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Georgetown Green Co Tenn</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 25, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 15, 1911, to March 25, 1911, that I last saw her alive on March 25, 1911, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:
Tuberculosis (quick)
239 78

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Hereditary
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. G. Scrumples M. D.
(Address) Wyaconda 191____

* 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) L. Morris
(ADDRESS) Womouth Ill.

PLACE OF BURIAL OR REMOVAL Town Mo. DATE OF BURIAL March 27, 1911

Filed April 27, 1911 R. G. Callahan
REGISTRAR

UNDERTAKER J. J. Smith ADDRESS Town 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*, *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.)



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PLACE OF DEATH

County Clark
Township Wyaconda
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 809 File No. 13773
Primary Registration District No. 6054 Registered No. 5

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

FULL NAME Miss Minnie Bell Dial

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH March 25, 1911
(Month) (Day) (Year)

DATE OF BIRTH Oct. 2nd, 1895
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 15, 1911, to March 25, 1911, that I last saw her alive on March 25, 1911, and that death occurred, on the date stated above, at 4:30 p.m.

AGE 15 yrs. 5 mos. 23 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Respiratory disease (pneumonia)

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

BIRTHPLACE Moody Creek Jefferson
(City or town, State or foreign country) Mo. Tenn.

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Heart
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) A. C. Crumley M. D.
1911 (Address) Wyaconda

PARENTS
NAME OF FATHER Robt Anderson Dial
BIRTHPLACE OF FATHER New Market Jefferson
(City or town, State or foreign country) Mo. Tenn.
MAIDEN NAME OF MOTHER Julia Kile
BIRTHPLACE OF MOTHER Greenville
(City or town, State or foreign country) Mo. Tenn.

*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) A. Morris
(ADDRESS) Monmouth Ill

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 _____

Filed 3/27 1911 R. E. Brown REGISTRAR

PLACE OF BURIAL OR REMOVAL Grain Mo DATE OF BURIAL March 27, 1911
UNDERTAKER J. T. Smith ADDRESS Grain Mo

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.

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.)

