

Howden

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

PLACE OF DEATH

County Jasper
 Township Joplin
 or
 Village
 or
 City Webb City (NO. N. Madison St. _____ Ward _____)

Registration District No. 417 File No. 28600
 Primary Registration District No. 3021 Registered No. 174

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

FULL NAME Loretta Mackey

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Child</u>
DATE OF BIRTH <u>May 13, 1911</u> (Month) (Day) (Year)		
AGE : <u>2 yrs. 2 mos. 18 ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Child</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 1, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 25, 1911, to Aug 1, 1911, that I last saw her alive on Aug 1, 1911, and that death occurred, on the date stated above, at 50 m. The CAUSE OF DEATH* was as follows:
Meningitis N 119B
7913

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

PARENTS	NAME OF FATHER <u>Leroy Mackey</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Bloomfield mo.</u>
	MAIDEN NAME OF MOTHER <u>Alice Bryson</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kans.</u>

(Duration) _____ yrs. _____ mos. 10 ds.
 Contributory Bowel Trouble
 (SECONDARY) (Duration) _____ yrs. _____ mos. 2002 ds.
 (Signed) A S Grouden M. D.
Aug 2, 1911 (Address) mo. City 40

*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) Lorretto Mackey
 (ADDRESS) Webb City mo.

PLACE OF BURIAL OR REMOVAL <u>Webb City cem</u>	DATE OF BURIAL <u>Aug 2 1911</u>
UNDERTAKER <u>Webb City</u>	ADDRESS <u>Webb City mo</u>

Filed Aug 3, 1911. E. H. Baird.
 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*, *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 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.)



PLACE OF DEATH

Jasper

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

County

Township

or

Village

or

City

Registration District No.

417

File No.

Primary Registration District No.

3021

Registered No.

124

(No. *11*)

St.

Ward

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

FULL NAME

Lorretta Mackey? (Correct & H. Baird)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *F* COLOR OR RACE *M.* SINGLE MARRIED WIDOWED OR DIVORCED *S.*
(If wife the word)

DATE OF DEATH *8-1-1911*
(Month) (Day) (Year)

DATE OF BIRTH *May 12 1911*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *8-25*, 1911, to *8-1*, 1911,

AGE *2* yrs. *18* mos. *18* ds. if LESS than 1 day, hrs. or min.

that I last saw her alive on *8-1*, 1911, and that death occurred, on the date stated above, at *500* m.

OCCUPATION (a) Trade, profession, or particular kind of work *None.*
(b) General nature of industry, business, or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows:
Meningitis

BIRTHPLACE (City or town, State or foreign country) *Webb City Mo.*

Contributory *Bowel Trouble,*
(Duration) yrs. mos. ds.

NAME OF FATHER *Comp Mackey.*

(Signed) *J. S. Grayson* M. D.
(Duration) yrs. mos. ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) *Blufffield Mo.*

(Address) *Webb City Mo.*

MAIDEN NAME OF MOTHER *Gene Bryson.*

BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Kno*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Lorretta Mackey* *(Correct & H. Baird)*

(ADDRESS) *Webb City Mo.*

Filed *Aug 3* 1911 *(Correct & H. Baird)* REGISTRAR

Original file, date *Aug*, 19*11*

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL *Webb City Cem.* DATE OF BURIAL *8-2-1911*

UNDERTAKER *Webb City Ind. Co.* ADDRESS *Webb City*

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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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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