

N. B.—Every item of information should be accurately supplied, or, if not known, so stated. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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

PLACE OF DEATH
County Saline
Township Miami
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 797 File No. 36598
Primary Registration District No. 6040 Registered No. _____

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

FULL NAME Delia May Morrow

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OF RACE white SINGLE MARRIED single WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH Oct 11, 1911
(Month) (Day) (Year)

AGE 7 yrs. 7 mos. 6 ds. if LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country) Near Miami Mo

PARENTS
NAME OF FATHER Wm. H. Morrow Jr.
BIRTHPLACE OF FATHER (City or town, State or foreign country) Saline Co. Mo
MAIDEN NAME OF MOTHER Blanche Finelle
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Saline Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willie Morrow

(ADDRESS) Miami Mo

Filed Oct-17th 1911 Wm. H. Sullivan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 17, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
No Dr. attended the body
Death was sudden
Cause of death unknown
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Probably premature birth
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ (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 Harmony Cemetery DATE OF BURIAL Oct 17, 1911

UNDERTAKER Est. Lounsbury ADDRESS Miami 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, 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
 County Saline
 Township Miami
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 797 File No. _____
 Primary Registration District No. 6040 Registered No. _____

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

FULL NAME Delia May Morrow

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>7</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>P.</u> (Write the word)
DATE OF BIRTH <u>Oct 11</u> , 19 <u>11</u> (Month) (Day) (Year)		
AGE <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds.		If LESS than 1 day, <u>6</u> hrs. or <u>6</u> 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)		
BIRTHPLACE (City or town, State or foreign country) <u>Near Miami, Mo</u>		
PARENTS	NAME OF FATHER <u>H. M. Morrow Jr.</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Saline Co Mo</u>	
	MAIDEN NAME OF MOTHER <u>Blanche Triell</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 17, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw h. alive on _____, 191____,
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
no doctor attended the baby - Death was sudden - cause of death unknown.

Contributory Probably premature birth
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. D. Good
Oct-17, 1911 (Address) Saline, 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) Willie Morrow
 (ADDRESS) Miami Mo
 Filed Nov-11, 1911 Frank H. Sullivan REGISTRAR

PLACE OF BURIAL OR REMOVAL Harmony, Mo DATE OF BURIAL Oct 17, 1911
 UNDERTAKER G. J. Cunningham ADDRESS Miami Mo

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 septichoemia," "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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