

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 Wayne
Township Mill Spring
or
Village Keeper
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 895 File No. 40313
Primary Registration District No. 6197 Registered No. 25

FULL NAME

Verdine Abner

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

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>June</u> <u>5</u> , <u>1908</u> (Month) (Day) (Year)		
AGE <u>3</u> yrs. <u>5</u> mos. <u>10</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>T. O</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Illigintimati</u>		
PARENTS	NAME OF FATHER <u>✓</u>	
	BIRTHPLACE OF FATHER <u>✓</u> (City or town, State or foreign country) _____	
	MAIDEN NAME OF MOTHER <u>Belle Brown</u>	
	BIRTHPLACE OF MOTHER <u>✓</u> <u>Reynolds Co</u> (City or town, State or foreign country)	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Belle Abner

(ADDRESS) Keeper Mo

Filed Nov 16, 1911, W. S. Bailey

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 15, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 25, 1911, to Nov 14, 1911, that I last saw her alive on Nov 14, 1911, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Malarial Fever
38

Contributory nothing
(SECONDARY) (Duration) about yrs. 1 mos. _____ ds.

(Signed) W. S. Bailey M. D.
Nov 15, 1911 (Address) Keeper 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 _____

PLACE OF BURIAL OR REMOVAL

Howard Cemetery

DATE OF BURIAL

Nov 16, 1911

UNDERTAKER

W. S. Bailey

ADDRESS

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.)



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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County Wayne
Township Mill Spring
or
Village
or
City

Registration District No. 895
Primary Registration District No. 6197

File No. 40313
Registered No. 25

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

FULL NAME

Verdine Abner

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED S.
(Write the word)

DATE OF BIRTH June 5, 1908
(Month) (Day) (Year)

AGE 3 yrs. 5 mos. 10 ds. IF LESS than 1 day, hrs. or min.?

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS
NAME OF FATHER W. S. Bailey
BIRTHPLACE OF FATHER Wayne Co. Mo.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Betty Abner
BIRTHPLACE OF MOTHER Wayne Co. Mo.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Betty Abner
(ADDRESS) Leeper, Mo.

Filed Jan 10, 1911 W. S. Bailey
REGISTRAR

Original file, date Nov 16, 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 15, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 25, 1911, to Nov 14, 1911, that I last saw her alive on Nov 14, 1911, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Malarial Fever
(Duration) about yrs. 1 mos. ds.

Contributory (SECONDARY) W. S. Bailey M. D.
(Duration) yrs. mos. ds.
(Signed) W. S. Bailey
Nov 15, 1911 (Address) Leeper, 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.

PLACE OF BURIAL OR REMOVAL Wooded Cem. DATE OF BURIAL Nov 16, 1911

UNDERTAKER None ADDRESS

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.)