

N. B.—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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Vernon</i>	Registration District No.	<i>880</i>	File No.	<i>3897</i>
Township	<i>Walton</i>	Primary Registration District No.	<i>6168</i>	Registered No.	<i>2</i>
Village		City	(NO. _____) St. _____	Ward	
FULL NAME			<i>Mary Francis Hicks</i>		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>Jan 21 1912</i> (Month) (Day) (Year)		
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from		
<i>June 4 1891</i> (Month) (Day) (Year)			<i>Jan 1 1912</i> , to <i>Jan 21 1912</i> ,		
AGE			that I last saw her alive on <i>Jan 20 1912</i> ,		
<i>20 yrs. 7 mos. 17 ds.</i>			and that death occurred, on the date stated above, at <i>8 P.M.</i>		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work <i>House wife</i>			<i>Fractured Femur</i>		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>9-0</i>			<i>186A</i>		
BIRTHPLACE			(Duration) _____ yrs. _____ mos. _____ ds.		
(City or town, State or foreign country) <i>Odd, Co. Ky.</i>			<i>Contributory Acute Contritis</i>		
PARENTS	NAME OF FATHER	<i>J. W. Graham</i>	(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.		
	BIRTHPLACE OF FATHER	<i>N. C.</i>	(Signed) <i>C. H. Moore</i> M. D.		
	MAIDEN NAME OF MOTHER	<i>Danflorian</i>	<i>Jan 21 1912</i> (Address) <i>Walton Mo</i>		
	BIRTHPLACE OF MOTHER	<i>Leestington Ky.</i>	*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			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
(Informant) <i>Mrs Martha Tucker</i>			At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.		
(ADDRESS) <i>Moundville Mo.</i>			Where was disease contracted If not at place of death?		
Filed <i>Jan 22 1912</i>			Former or usual residence <i>Ky.</i>		
REGISTRAR <i>C. B. Davis Mo</i>			PLACE OF BURIAL OR REMOVAL		DATE OF BURIAL
			<i>Nevada Mo.</i>		<i>Jan 22 1912</i>
			UNDERTAKER		ADDRESS
			<i>Wainwright &amp; Co</i>		<i>Wade Mo</i>

# 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.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County Vermont  
 Township Swanton  
 or  
 Village  
 or  
 City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

Registration District No. 880 File No. 3897  
 Primary Registration District No. 6168 Registered No. 2

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

FULL NAME Mary Francis Hiers

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widow</u> (Write the word)
DATE OF BIRTH <u>6/4</u> , 18 <u>91</u> (Month) (Day) (Year)		
AGE <u>70</u> yrs. <u>7</u> mos. <u>17</u> ds. If LESS than 1 day, hrs. or min.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Ky.</u>		
PARENTS	NAME OF FATHER <u>Wm. G. Hiers</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Supplem</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
1/21, 1922  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1922, to 1-21, 1922, that I last saw her alive on 1-20, 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:  
Fracture of Femur from fall  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY)  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Euteria C. H. Moxey M. D.  
Jan 21, 1922 (Address) Waver

\*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) Mrs. Martha Tucker  
 (ADDRESS) Moundville, W. Va.

PLACE OF BURIAL OR REMOVAL  
Waver  
 DATE OF BURIAL  
1-22, 1922  
 UNDERTAKER  
Waver  
 ADDRESS  
Waver

Filed Jan 22, 1922 at Ch. Davis M.D.  
 REGISTRAR

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