

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

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.

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

PLACE OF DEATH  
County Linn  
Township Crown Ridge  
or  
Village  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 509 File No. 10036  
Primary Registration District No. 5677 Registered No. 7

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

FULL NAME Richard Lee Blue

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OF RACE <u>White</u>	SINGLE— MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>March 18<sup>th</sup></u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>March 14<sup>th</sup></u> , 18 <u>55</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>March 10<sup>th</sup></u> , 191 <u>2</u> , to <u>March 18<sup>th</sup></u> , 191 <u>2</u> , that I last saw her alive on <u>March 18<sup>th</sup></u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>3 pm</u> . The CAUSE OF DEATH* was as follows: <u>Albuminuria</u> <u>814</u>	
AGE <u>57</u> yrs. — <u>14</u> mos. — <u>14</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?			6 (Duration) ___ yrs. ___ mos. <u>10</u> ds.	
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) <u>9-0</u>			Contributory <u>Chronic myelitis</u> (SECONDARY) (Duration) <u>4</u> yrs. ___ mos. ___ ds.	
BIRTHPLACE (City or town, State or foreign country) _____ X			(Signed) <u>Wm. H. Adams</u> M. D. <u>March 19</u> , 191 <u>2</u> (Address) <u>Chula Mo</u>	
PARENTS	NAME OF FATHER _____ X		*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 <u>13</u> yrs. ___ mos. ___ ds. In the <u>35</u> yrs. ___ mos. ___ ds. Where was disease contracted <u>at place of death</u> if not at place of death? _____ Former or usual residence <u>Ohio</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____ X			
	MAIDEN NAME OF MOTHER _____ X			
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____ X			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. W. Blue</u> <u>Husband</u> (ADDRESS) <u>Chula, Mo.</u>			PLACE OF BURIAL OR REMOVAL <u>May Cemetery</u>	
Filed <u>3-19</u> 191 <u>2</u> <u>W. H. Adams</u> REGISTRAR			DATE OF BURIAL <u>3-20</u> 191 <u>2</u>	
			ADDRESS <u>Chula Mo.</u>	

# 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 Linn  
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Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 509 File No. \_\_\_\_\_  
Primary Registration District No. 5677 Registered No. 7

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

FULL NAME

Rachael Ann Blue

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED m  
(Write the word)

DATE OF BIRTH Mar 14, 1912  
(Month) (Day) (Year)

AGE 5-7 yrs. 14 mos. 14 ds. If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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

BIRTHPLACE (City or town, State or foreign country) Ohio

PARENTS NAME OF FATHER Lee Hunt Rhyer  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio

MAIDEN NAME OF MOTHER Raney Davis  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE True  
(Informant) J. W. Blue  
(ADDRESS) Chula Mo.

Filed 5-10 1912 Thos. C. Graham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 18, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3/10, 1912, to 3/18, 1912,  
that I last saw her alive on 3/18, 1912,  
and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH\* was as follows:  
Bulbar Paralysis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.  
Contributory Chronic Myelitis  
(SECONDARY) (Duration) 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Thos. C. Graham M. D.  
Mar 18, 1912 (Address) Chula 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 May Cem DATE OF BURIAL 3/20, 1912  
UNDERTAKER M. D. Baath ADDRESS Chula Mo.

Original file, date MAR 18, 1912 All information called for must be written on this Supplementary Certificate.

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