

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 St. Louis

County Lewis

Township Salmon

Village St. Louis

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 485

File No. 14103

Primary Registration District No. 5648

Registered No. _____

FULL NAME Catherine Carlin

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE Married MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Feb 16 1943
(Month) (Day) (Year)

AGE 69 yrs. 2 mos. 1 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Home mfg.
(b) General nature of Industry, business, or establishment in which employed (or employer) Home mfg. & Retail

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

NAME OF FATHER Wiley Ballard

BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky

MAIDEN NAME OF MOTHER Catherine Edwards

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ben Rife

(ADDRESS) Steffenville, Mo

Filed April 11 1943 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 11 1943
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 12, 1942, to April 10, 1943 that I last saw him alive on April 11, 1943, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis with Paralysis

(Duration) 2 yrs. 2 mos. 0 ds.

Contributory (SECONDARY) Arterio Sclerosis
(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) Paul Feale M. D.
(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 3 yrs. 3 mos. 0 ds. In the State 50 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death? Steffenville, Mo

Former or usual residence Shelby County, Mo

PLACE OF BURIAL OR REMOVAL St. Pleasant DATE OF BURIAL 4/18 1943

UNDERTAKER Lee Allen ADDRESS Steffenville

416

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

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

PLACE OF DEATH

County _____
 Township _____ Registration District No. _____ File No. _____
 or Village _____ Primary Registration District No. _____ Registered No. _____
 or City _____ (NO. _____ St. _____ Ward _____)
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
	DATE OF BIRTH	

_____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min. ?

OCCUPATION
 (a) Trade, profession, or particular kind of work _____
 (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 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Address) _____ M. D.

BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Address) _____ M. D.

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

(ADDRESS) _____

CONTRIBUTORY
 (secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Address) _____ M. D.

*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 _____ 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	DATE OF BURIAL
_____	_____ 191_____

UNDERTAKER _____ **ADDRESS** _____

Filed _____, 191____, _____ REGISTRAR

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

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

PLACE OF DEATH

County Lewis
Township Salem
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 485 File No. 14103
Primary Registration District No. 5648 Registered No. _____

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

FULL NAME Catherine Carter

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M.</u>
DATE OF BIRTH <u>Feb 16</u> , 18 <u>83</u> (Month) (Day) (Year)		
AGE <u>69</u> yrs. <u>2</u> mos. <u>1</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>house wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>housekeeper</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Ky</u>		
PARENTS	NAME OF FATHER <u>Wiley Ballard</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ky</u>	
	MAIDEN NAME OF MOTHER <u>Hazel Edwards</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 11, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 15, 1912, to Apr 10, 1912, that I last saw her alive on Apr 11, 1912, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis with paralysis

(Duration) _____ yrs. 2 mos. _____ ds.

Contributory Arteriosclerosis
(SECONDARY) (Duration) 2 yrs. _____ mos. _____ ds.

(Signed) Paul F. Cole M. D.
Apr 13, 1912 (Address) Paul F. Cole

*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) Ben Rife
(ADDRESS) Steffinville Mo.
File Apr 12 1912 P. F. Cole REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Mt Pleasant</u>	DATE OF BURIAL <u>Apr 18</u> 191 <u>2</u>
UNDERTAKER <u>Lee Allen</u>	ADDRESS <u>Steffinville 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, 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, peritoneum*, etc., *Carcinoma, Sarcoma*, 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.)