

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 Scottland  
Township Thomson Registration District No. 708 File No. 19170  
Village \_\_\_\_\_ Primary Registration District No. 6023 Registered No. 6  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

FULL NAME Laura E. Trout

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

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> <small>(Write the word)</small>	DATE OF DEATH <u>May 6</u> , 191 <u>2</u> <small>(Month) (Day) (Year)</small>
DATE OF BIRTH <u>Mar. 11</u> , 19 <u>58</u> <small>(Month) (Day) (Year)</small>		I HEREBY CERTIFY, that I attended deceased from <u>Apr 9</u> , 191 <u>1</u> , to <u>May 6</u> , 191 <u>2</u> , that I last saw her alive on <u>May 6</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>7 P.M.</u>	
AGE <u>54</u> yrs. <u>1</u> mos. <u>25</u> ds. <small>IF LESS than 1 day, ___ hrs. or ___ min.?</small>		The CAUSE OF DEATH* was as follows: <u>Ovarian cancer</u>	
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>0 0</u>		<u>49A</u> <small>(Duration) ___ yrs. ___ mos. ___ ds.</small>	
BIRTHPLACE (City or town, State or foreign country) <u>Ohio</u>		Contributory <small>(SECONDARY)</small> <small>(Duration) ___ yrs. ___ mos. ___ ds.</small>	
PARENTS	NAME OF FATHER <u>Nathan Beach</u>		Signed <u>A. L. Davis</u> M. D. <u>May 7</u> , 191 <u>2</u> (Address) <u>Arbela Mo.</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>		
	MAIDEN NAME OF MOTHER <u>Jessie Campbell</u>		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Va.</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>S. M. Beach</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
(ADDRESS) <u>Arbela Mo.</u>		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 _____	
Filed <u>May 7</u> , 191 <u>2</u> <u>A. L. Davis</u> REGISTRAR		PLACE OF BURIAL OR REMOVAL <u>Arbela Mo.</u> DATE OF BURIAL <u>May 7</u> , 191 <u>2</u>	
		UNDERTAKER <u>John S. Murch</u> ADDRESS <u>Memphis</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.)



PLACE OF DEATH  
 County Scotland  
 Township Thomson  
 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. 808 File No. 19170  
 Primary Registration District No. 6053 Registered No. 6

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

FULL NAME Laura E. Trout

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F.</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Wid.</u>
DATE OF BIRTH <u>March 11</u> , 19 <u>55</u> (Month) (Day) (Year)		
AGE <u>54</u> yrs. <u>1</u> mos. <u>25</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)		
BIRTHPLACE (City or town, State or foreign country) <u>Madison, Mo.</u>		
PARENTS	NAME OF FATHER <u>Nathan Beach</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Deliah Campbell</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Va.</u>	

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH <u>May 6</u> , 19 <u>22</u> (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from <u>April 28</u> , 19 <u>21</u> , to <u>May 6</u> , 19 <u>22</u> , that I last saw her alive on <u>May 6</u> , 19 <u>22</u> , and that death occurred, on the date stated above, at <u>7 P.</u> m.
The CAUSE OF DEATH* was as follows: <u>Ovarian cancer</u>
(Duration) _____ yrs. <u>1</u> mos. <u>2</u> ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) <u>A. L. Davis</u> M. D. <u>May 7</u> , 19 <u>22</u> (Address) <u>Arbela Mo.</u>
*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) S. M. Beach  
(ADDRESS) Arbela Mo.

Filed June 6, 1922 A. L. Davis  
REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Nickory Grove</u>	DATE OF BURIAL <u>May 7</u> , 19 <u>22</u>
UNDERTAKER <u>John H. Mulch</u>	ADDRESS <u>Memphis Mo.</u>

Original file, date MAY 6 1919 All information called for must be written on this Supplementary Certificate.

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Association]

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*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.)