MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

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

PLACE OF DEATH

County Scott

Township ~~Wrapper~~ Sandy Wood

or Village ~~Cary~~

or City

Registration District No. 815

Primary Registration District No. 6064

File No. 38002

Registered No. 67

(NO. St.: Ward)

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

FULL NAME Mable Hallman

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH March 31, 1909 (Month) (Day) (Year)

AGE 3 yrs. 6 mos. 22 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) Cary Scott Co Mo

PARENTS

NAME OF FATHER Robert L. Hallman

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

MAIDEN NAME OF MOTHER Willie Polk.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. L. Hallman

(ADDRESS) Benton Mo

Filed Nov 6, 1912 Fred L. Ogilvie REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 19th, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 10th, 1912, to Oct 19th, 1912, that I last saw her alive on Oct 18, 1912, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Malaria

38

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

Contributory (SECONDARY) ___

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. L. Seabaugh M. D.

10/28, 1912 (Address) Blodgett

*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 Blodgett Mo

DATE OF BURIAL 10-24, 1912

UNDERTAKER B. Marshall Mo Co

ADDRESS Blodgett Mo

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 used only when needed. As examples: (*a*) *b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery; nan,* (*b*) *Automobile factory.* The material ı may form part of the second statement. turn "Laborer," "Foreman," "Manager," etc., without more precise specification, as *er, Farm laborer, Laborer—Coal mine,* etc. home, who are engaged in the duties of the only (not paid *Housekeepers* who receive a lary), may be entered as *Housewife, House-lt home,* and children, not gainfully employed, *ool* or *At home.* Care should be taken to re-ically the occupations of persons engaged in ıervice for wages, as *Servant, Cook, House-* 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, 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," "[illegible]" "Uraemia," "Weakness," etc., when a definite can be ascertained as the cause. Always qu diseases resulting from childbirth or miscar "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis*" State cause for which surgical operation wa taken. For VIOLENT DEATHS state MEANS OF IN qualify as ACCIDENTAL, SUICIDAL, or HOMICIDA *probably* such, if impossible to determine Examples: *Accidental drowning; Struck by train—accident; Revolver wound of head—h Poisoned by carbolic acid—probably suicide.* ture of the injury, as fracture of skull, an quences (e. g., *sepsis, tetanus*) may be stated u head of "Contributory." (Recommendations ment of cause of death approved by Committee on Nomenclature of the American Medical Association.)

STATE

JEFFER

HUGH STEPHENS, JEFFERSON CITY.