

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every 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

County

Butas

Township

Grand Rivers

or

Village

or

City

(NO.

St.:

Ward)

FULL NAME

*Oris Lucile Murphy*MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

1081

File No.

134 4

Primary Registration District No.

5088

Registered No.

4

(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

CHOICE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

*Oct**28**1912*

(Month)

(Day)

(Year)

AGE

2 yrs. *5* mos. *5* ds.

If LESS than
1 day, — hrs.
or — min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

Adrian Mo

NAME OF FATHER

James Murphy

BIRTHPLACE OF FATHER

Missouri

MAIDEN NAME OF MOTHER

Sally Reynolds

BIRTHPLACE OF MOTHER

Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Minnie Corue

(ADDRESS)

Adrian Mo

Filed

Jan 7

1913

M. H. Blankenship

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

*Jan**4**1913*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

Jan 4, 1913, to *Jan 13*, 1913,that I last saw ~~her~~ alive on *Jan 3*, 1913,and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

S. L. Balis

M. D.

Jan 4, 1913

(Address)

Adrian 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

Adrian Mo

DATE OF BURIAL

Jan 5, 1913

UNDERTAKER

H. Hoar

ADDRESS

Adrian 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 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.)



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

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PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

County Bales Registration District No. 1081 File No. 1
 Township Grand River or Village _____ Primary Registration District No. 5088 Registered No. 4
 City _____ (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Orrie Lucile Murphy

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Oct. 28</u> , 191 <u>2</u> (Month) (Day) (Year)		
AGE <u>2</u> yrs. <u>5</u> mos. <u>5</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Adrian Mo.</u>		
PARENTS	NAME OF FATHER <u>James Murphy</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Sally Reynolds</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan. 4, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 4, 1913 to Jan. 3, 1913, that I last saw her alive on Jan. 3, 1913, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:
Pneumonia

Sobor Pneumonia

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

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

(Signed) S. L. Bates M. D. Jan. 4, 1913 (Address) Adrian 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
Altona Mo.

DATE OF BURIAL
Jan. 6, 1913

UNDERTAKER
J. J. Carr

ADDRESS
Adrian Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Cruise
(ADDRESS) Adrian Mo.

Filed Jan 7, 1913. M. Y. Blankenship
REGISTRAR

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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 "Asthemia," "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.)

134