

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.

PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>H</i>	COLOR, OR RACE <i>B</i>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Widowed</i>
DATE OF BIRTH <i>Feb 27</i> (Month) (Day) (Year)		
AGE <i>71</i> 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

BIRTHPLACE OF FATHER

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from *Jan 11*, 191*3*, to *Jan 21*, 191*3*, that I last saw him alive on *Jan 21*, 191*3*, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH was as follows:

*Lobar Pneumonia.*  
*10*  
*958*

Contributory

(SECONDARY)

(Signed)

*H H Webb* M. D.  
*Jan 27*, 191*3* (Address) *Marshall 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

DATE OF BURIAL

UNDERTAKER

ADDRESS

# 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.)



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

CERTIFICATE OF DEATH

PLACE OF DEATH  
County Salem  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City Marshall (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 796 File No. \_\_\_\_\_  
Primary Registration District No. 3038 Registered No. 5-

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

FULL NAME

Susan Hinchey

## PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE black SINGLE widowed  
MARRIED  
WIDOWED  
(Write the word)

DATE OF BIRTH Feb 27 1932  
(Month) (Day) (Year)

AGE 71 yrs. 71 mos. 71 ds. If LESS than 1 day, hrs. or min.?

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

Housewife

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

BIRTHPLACE  
(City or town, State or foreign country)

Mo.

NAME OF FATHER Thornton Crawford

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

MAIDEN NAME OF MOTHER Don't know

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

Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rebecca Smithfield

(ADDRESS) Marshall, Mo.

Filed Mar 6 1933 A. C. Putnam

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 21 1933  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 11 1933, to Jan. 21 1933, that I last saw her alive on Jan. 21 1933, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Cardiac Hypertrophy  
(SECONDARY)

(Signed) H. H. Webb M. D.  
Jan. 22 1933 (Address) Marshall 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 Fairview Cemetery DATE OF BURIAL Jan. 26 1933

UNDERTAKER Campbell & Shaffer ADDRESS Marshall Mo.

Original file, date 24 1933 All information called for must be written on this Supplementary Certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERM.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

# 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 "*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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