

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.

WHILE FILLING IN, WITH UNFADING INK THIS IS A PERMANENT RECORD

PLACE OF DEATH

County Wright
Township Union
or
Village
or
City (NO. _____ St. _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 9480 File No. 12046 11946
Primary Registration District No. 6220 Registered No. 5

FULL NAME Child Unnamed (Ballard)

[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 WIDOWED OR DIVORCED (If write the word) —
DATE OF BIRTH March 17, 1913
(Month) (Day) (Year)
AGE — yrs. — mos. 11 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) — 0-0

BIRTHPLACE
(City or town, State or foreign country) Grove Spring Mo

PARENTS
NAME OF FATHER Unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
MAIDEN NAME OF MOTHER Esther Ballard
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jim Ballard
(ADDRESS) Grove Spring Mo

Filed 3-29-13 Dr. J. R. West REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 28, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____
that I last saw h_____ alive on _____, 191____
and that death occurred, on the date stated above, at 49 m.
The CAUSE OF DEATH* was as follows:

without medical attendance
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Dr. J. R. West M. D. 3-29-13 (Address) Grove Spring 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 Shady Cemetery DATE OF BURIAL 3-29-13

UNDERTAKER D. Dennis ADDRESS Grove Spring Mo.



Standard Certificate

id American Public Health
tion)

lon.—Precise statement of so that the relative health can be known. The question of person, irrespective of age. The word or term on the first form or Planter, Physician, Fire engine, Civil engineer, in many cases especially in necessary to know (a) the nature of the business or industrial line is provided for be used only when needed. Cotton mill; (a) Salesman, Automobile factory. The part of the second statement, "Foreman," "Manager," more precise specification, as Day laborer—Coal mine, etc. Women the duties of the household to receive a definite salary), Housework, or At home, and d, as At school or At home. Specifically the occupations service for wages, as Serv of the occupation has been at of the DISEASE CAUSING beginning of illness. If may be indicated thus: persons who have no occu-

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 "*Assthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Con-*
genital," "*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 septichaemia*," "*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.)

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*;

FROM

V. 3, FORM XXX

STATE BOARD OF HEALTH
Bureau of Vital Statistics
JEFFERSON CITY, . . . MISSOURI

JEFFERSON CITY, - MISSOURI