

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

PLACE OF DEATH

County Jasper

Township Galena

Village _____

City _____

Registration District No. 411

File No. 13475

Primary Registration District No. 2003

Registered No. 197

(NO. Post House 26th St. 5569)

Ward _____

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

FULL NAME Hellen Dodson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(If write the word)

DATE OF BIRTH April 4, 1913
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. 18 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) O - O

BIRTHPLACE (City or town, State or foreign country) Post House 26th St. MO

NAME OF FATHER Joseph Dodson

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

MAIDEN NAME OF MOTHER Myrtle

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myrtle Dodson
(ADDRESS) Chetwood mo

Filed 4-23, 1913 A.M. Gregg
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 22, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 4-4, 1913, to 4-22, 1913, that I last saw her alive on 4-22, 1913, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

1180 Acute Indigestion

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

Contributory (SECONDARY) malnutrition

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

(Signed) W.D. M.D.

4-22, 1913 (Address) Jasper 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 Jasper DATE OF BURIAL 4/23, 1913

UNDERTAKER Hurlbut Co. ADDRESS Jasper

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 I LINGER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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, 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," "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.)

CERTIFICATE OF DEATH

PLACE OF DEATH

County Jasper
Township Galena
or
Village _____
or
City _____ (NO. Post House W. 26 St. _____ Ward _____)

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

Registration District No. 411 File No. †
Primary Registration District No. 5569 Registered No. 197

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

FULL NAME Nellen Dodson

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE S.
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Apr. 4, 1913
(Month) (Day) (Year)

AGE _____ IF LESS than 1 day, _____ hrs. or _____ min.
yrs. mos. 18 ds.

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) Post House W. 26 Mo.

PARENTS
NAME OF FATHER Joseph Dodson
BIRTHPLACE OF FATHER Mo.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mary Hickey
BIRTHPLACE OF MOTHER Mo.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myrtle Dodson
(ADDRESS) Lehitwood Mo.

Filed 4-23 1913 J. M. Guss
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 22, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
(that I last saw him or her) Satisfactory Information Supplied.
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ 191____ (Address) _____
Satisfactory Information Supplied.

*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 _____ 191____
UNDERTAKER _____ ADDRESS _____
Satisfactory Information Supplied.

N. B.—Every item of info. should be carefully checked. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain, concise terms, so that it may be properly classified. THIS INFORMATION IS VERY IMPORTANT.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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