

THIS IS A PLAIN COPY OF THE ORIGINAL RECORD

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.

You will see

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

PLACE OF DEATH
County Green
Township _____
or
Village _____
or
City Springfield (NO. 334 1/2 rd West St. 7 Ward)

Registration District No. 318 File No. 16263
Primary Registration District No. 2001 Registered No. 258

FULL NAME Frances M. Nelson

[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 —
(Write the word)
DATE OF BIRTH April 15, 1913
(Month) (Day) (Year)
AGE 1 yrs. 1 mos. 0 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) Springfield

PARENTS
NAME OF FATHER Geo Clark
BIRTHPLACE OF FATHER Miss
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Birtha Nelson
BIRTHPLACE OF MOTHER Springfield
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nelson
(ADDRESS) Springfield, Mo

Filed May 6, 1913 D. C. W. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 6, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 3, 1913, to May 6, 1913, that I last saw her alive on May 6, 1913, and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Mal Nutrition
158
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Small Infant's Injury
(SECONDARY)
(Signed) Robert F. Williams M. D.
May 6, 1913 (Address) Springfield

*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 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 Hazelwood DATE OF BURIAL May 7, 1913

UNDERTAKER W. J. Major ADDRESS Springfield

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*, *Composer*, *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, 8 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.)

WE ARE PLAIN WITH UNFADING INK - 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.

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

PLACE OF DEATH
County Greene
Township _____
or
Village _____
or
City Springfield (NO. 534 1/2 U. Street St. 7 Ward)

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

Registration District No. 318 File No. _____

Primary Registration District No. 2001 Registered No. 258

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

FULL NAME Francis M. Nelson.

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Satisfactory Information Supplied.

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
Satisfactory Information Supplied.

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min.
Satisfactory Information Supplied.

OCCUPATION (a) Trade, profession, or particular kind of work: _____ (b) General nature of industry, business, or establishment in which employed (or employer): _____
Satisfactory Information Supplied.

BIRTHPLACE (City or town, State or foreign country) _____
Satisfactory Information Supplied.

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____
Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Satisfactory Information Supplied.
(ADDRESS) _____

Filed June 30 1913 D. C. W. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 6, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____
Satisfactory Information Supplied.
(that I last saw h _____ alive on _____, 1913)

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
mal nutrition. Mother said nothing was eaten with the baby and was doing of starvation when I saw it.
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory small delicate baby
(Duration) _____ yrs. _____ mos. _____ ds.
Signed Robert F. Weigman M. D.
May 6, 1913 (Address) Springfield

*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 Satisfactory information DATE OF BURIAL _____ 1913

UNDERTAKER _____ ADDRESS Satisfactory information

Revised United States Standard Certificate of Death

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

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