

PLACE OF DEATH

County Ray Co. Mo.MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Township _____

Registration District No. 744File No. 27494

Village _____

Primary Registration District No. 3035Registered No. 182City Richmond (NO. _____)

St.: _____ Ward _____

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

FULL NAME Elizabeth Warrick

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED Widowed WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH Aug 15, 1946
(Month) (Day) (Year)AGE 68 yrs. 13 mos. 13 ds. If LESS than 1 day, _____ hrs. or _____ min.?OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) House workBIRTHPLACE (City or town, State or foreign country) WalesPARENTS NAME OF FATHER David ThomasBIRTHPLACE OF FATHER (City or town, State or foreign country) WalesMAIDEN NAME OF MOTHER Donna KnorrBIRTHPLACE OF MOTHER (City or town, State or foreign country) Donna Knorr

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Williams(ADDRESS) Richmond MoFiled Aug 30, 193, Geo W Hunt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8-28, 193
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from May, 191, to Aug 28, 193, that I last saw her alive on Aug 28, 193, and that death occurred, on the date stated above, at 10 A m. The CAUSE OF DEATH* was as follows:ParalysisSIH2717 (Duration) 2 yrs. _____ mos. _____ ds.Contributory Mitral Insufficiency (SECONDARY) (Duration) 2 yrs. _____ mos. _____ ds.(Signed) F. T. W. Young M. D. 8-30, 193 (Address) Richmond

*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 City Cemetery DATE OF BURIAL Aug 30, 193UNDER-TAKER Shumett ADDRESS Richmond Mo

PLACE OF DEATH

County _____
 Township _____
 or Village _____
 or City _____ (NO. _____)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If fill the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ 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)

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant)

(ADDRESS)

Filed _____, 191____, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____ (Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased _____

_____, 191____, to _____, 191____
 that I last saw him _____ alive on _____, 191____
 and that death occurred, on the date stated above, at _____
 The CAUSE OF DEATH* was as follows:

 _____ (Duration) _____ yrs. _____ mos.
 _____ (Duration) _____ yrs. _____ mos.
 _____ (Address) _____
 _____, 191____

Contributory
 (SECONDARY)

(Signed)

*State the Disease Causing Death, or, in deaths from Violence (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TOURS, ETC.)
 At place _____ yrs. _____ mos. _____ ds. State _____
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

offr. bell? _____

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 Ray COUNTY Ray TOWNSHIP _____ REGISTRATION DISTRICT NO. 744 FILE NO. _____
 OR _____ PRIMARY REGISTRATION DISTRICT NO. 3035 REGISTERED NO. 182
 VILLAGE _____ CITY Richmond ST. _____ WARD _____
 FULL NAME Elizabeth Daniels

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

OCCUPATION (a) Trade, profession, or articular 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
 FATHER: NAME OF FATHER _____ BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
 MOTHER: MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____ Satisfactory Information Supplied
 (ADDRESS) _____

Filed _____ Aug. 30 1913 _____ Geo. W. Hunt _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year)
 I HEREBY CERTIFY, that I attended deceased from _____ to _____, 191____
 that I last saw h. _____ alive on _____, 191____
 and that death occurred, on the date stated above, at _____

Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:
Paralysis. Bulbous

63 (Duration) 2 yrs. _____ mos. _____ ds.

Contributory Mitral Insufficiency (SECONDARY) (Duration) Don't know yrs. _____ mos. _____ ds.

(Signed) E. P. M. [Signature] M. D. Aug. 30, 1913 (Address) Richmond

*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 Satisfactory Information Supplied.

Revised United States Standard Certificate

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*, *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.)

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