

N. B. Every kind of information should be accurately 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 *Ball*

County *Lafayette*

Township _____

or _____

Village _____

or _____

City *Lexington*

Registration District No. *461*

File No. *64 23135*

Primary Registration District No. *3824*

Registered No. _____

(NO. *South west Blvd* St.: *2* Ward)

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

FULL NAME *Emaline Davis*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *Female* COLOR OR RACE *Negro* SINGLE MARRIED *Widowed* WIDOWED OR DIVORCED (Writes the word)

DATE OF DEATH *June 14, 1914*
(Month) (Day) (Year)

DATE OF BIRTH *Don't know, 8/31*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Jan. 1st, 1914*, to *June 4, 1914*, that I last saw her alive on *June 13, 1914*, and that death occurred, on the date stated above, at *3:30 P.M.*

AGE *about 73* If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *At Home*

Cardiac Atrophy

BIRTHPLACE (City or town, State or foreign country) *Mo*

Duration, ___ yrs. ___ mos. ___ ds.

NAME OF FATHER *Dick Morton*

Contributory *Chronic Anterior Polymyositis*
(Secondary) (Duration) *10* yrs. ___ mos. ___ ds.

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

(Signed) *J. D. Ball* M. D.

MAIDEN NAME OF MOTHER *Don't know*

June 15, 1914 (Address) *Lexington Mo*

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death ___ yrs. ___ mos. ___ ds. In the ___ yrs. ___ mos. ___ ds. State ___ yrs. ___ mos. ___ ds.

(Informant) *Robert Davis*

Where was disease contracted If not at place of death? _____

(ADDRESS) *Lexington Mo*

Former or usual residence _____

Filed *July 8, 1914* *J. L. Cope* REGISTRAR

PLACE OF BURIAL OR REMOVAL *Lexington Mo* DATE OF BURIAL *June 16, 1914*

UNDERTAKER *Ernest Hegert* ADDRESS *Lexington Mo*

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, 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.)

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

PLACE OF DEATH
County Lafayette
Township _____
or
Village _____
or
City Exington (NO. _____)

Registration District No. H 61 File No. _____
Primary Registration District No. 9024 Registered No. 624

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

FULL NAME Eunaline Davis

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE B SINGLE Widowed
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

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

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

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) _____

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) _____
(ADDRESS) _____
Satisfactory Information Supplied

Filed Sept 11 1914 J. L. Coff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 14 1914
(Month) (Day) (Year)

Satisfactory 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, at _____ m.

The CAUSE OF DEATH* was as follows:
Cardiac Atrophy
Contributory Chronic Arteriosclerosis
(Duration) _____ yrs. _____ mos. _____ ds.

(SECOND BY)
J. D. Bates
(Signed) _____ M. D.
Exington Mo
(Address) _____

* 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

Original file, date, as shown on this statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

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

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23135

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