

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 Franklin
 Township Baker
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

Registration District No. 290 File No. 25791
 Primary Registration District No. 5408 Registered No. 61

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

FULL NAME Ruby Irene Brown

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>July 12, 1914</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>11</u> mos. <u>12</u> 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)
Franklin Co. Mo.

PARENTS	NAME OF FATHER <u>Walter G. Brown</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Brownsville Tenn</u>
	MAIDEN NAME OF MOTHER <u>Kara Johnson</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Loda Missis.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) Walter G. Johnson
 (ADDRESS) Smith Mo.

Filed Aug 25, 1914
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Aug. 27, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 23, 1914, to Aug 24, 1914, that I last saw her alive on Aug 24, 1914, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Malaria
04

Contributory (SECONDARY)
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) P. L. Jiptow M. D.
Aug 26, 1914 (Address) Smith, 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 <u>Smith County</u>	DATE OF BURIAL <u>8/24, 1914</u>
UNDERTAKER <u>Dr. P. M. Daniel</u>	ADDRESS <u>Smith Mo.</u>

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City.....

Registration District No.

File No.

Primary Registration District No.

Registered No.

City.....(NO.)

St.:.....Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If <i>write</i> the word)
DATE OF BIRTH	(Month).....(Day).....(Year).....	
AGEyrs.....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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month).....(Day).....(Year)..... 191

I HEREBY CERTIFY, that I attended deceased from

that I last saw h..... alive on....., 191....., to....., 191.....

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

The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY)

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

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

M. D.

(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

UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACT. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of... state

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

PLACE OF DEATH

County

Dunklin
Salem

Registration District No.

290
5408

File No.

Township

or

Village

or

City

Primary Registration District No.

Registered No.

61

St.: _____ Ward)

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

FULL NAME

Ruby Irene Brown

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

F
W
Single

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH

Aug. 24, 191*4*
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw _____, 191____, and that death occurred, on the _____, 191____, at _____ m.

The CAUSE OF DEATH* was as follows: _____

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)

Contributory (SECONDARY)

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

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

(Signed) _____ M. D.

(Address) _____, 191____

*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

Filed

8/30

R. W. H. [Signature]

AUG

1914

REGISTRAR

SUPPLEMENTARY Satisfactory Information Supplied

Physicians should state occupation in very important. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

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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