

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

PLACE OF DEATH

County Greene
Township Center
or
Village _____
or
City Springfield (NO. Burge Weaumont Ward)

Registration District No. 320 File No. 25901
Primary Registration District No. 3448 Registered No. 24

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

FULL NAME Alzora Salts

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX A COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)
DATE OF BIRTH Sept 3, 1900
(Month) (Day) (Year)
AGE 14 yrs. mos. ds. IF LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Aug. 23 — 1914
(Month) (Day) (Year)

OCCUPATION
(a) Trade, profession, or particular kind of work student
(b) General nature of industry, business, or establishment in which employed (or employer) "

I HEREBY CERTIFY, that I attended deceased from Aug. 17, 1914, to Aug. 23, 1914, that I last saw her alive on Aug. 23, 1914, and that death occurred, on the date stated above, at 11⁴⁵ a.m.

The CAUSE OF DEATH* was as follows:
Appendicitis,

BIRTHPLACE (City or town, State or foreign country) Missouri

12 1/2 (Duration) yrs. mos. ds.

PARENTS
NAME OF FATHER Joe Salts
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee
MAIDEN NAME OF MOTHER Elizabeth Walker
BIRTHPLACE OF MOTHER (City or town, State or foreign country) England

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

(Signed) J. W. Clark M. D.
Aug 23 - 1914 (Address) Burr D'Arcy Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Salts
(ADDRESS) Millard Mo.

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 _____

Filed Aug 29 1914 J. W. Clark REGISTRAR

PLACE OF BURIAL OR REMOVAL Cleer Creek DATE OF BURIAL Aug 24, 1914
UNDERTAKER W. C. Shively ADDRESS 300 W Walnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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, 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*, *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.)

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

PLACE OF DEATH
 County Franklin
 Township Center
 or
 Village _____
 or
 City _____ (NO. _____)

Registration District No. 320 File No. _____
 Primary Registration District No. 5443 Registered No. 24
 St. _____ Ward _____

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

FULL NAME Alzona, Sato

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____
(Month) (Day) (Year)

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

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

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed Aug 29 1914 H. Gardner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 23, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, that I last saw h _____ alive on _____, 191____, and that death occurred, on the date stated above, at 11:45 m.

The CAUSE OF DEATH* was as follows:
Appendicitis abscess
formed and was ruptured
No operation

(Duration) _____ yrs _____ mos. 6 ds.

Contributory (SECONDARY) 108
 (Duration) _____ yrs _____ mos. _____ ds.

Signed Aug 23 1914 (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 _____

AUG 1914

Revised United States Standard Certificate of Death

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

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