

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

County

Ripley

Township

Kelley

or
Village

or

City

(NO.

St.;

Ward)

FULL NAME

Mary Ball

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

Registration District No.

965

File No.

10 30130

Primary Registration District No.

5989

Registered No.

(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)

S

DATE OF BIRTH

June 22

(Month)

(Day)

1909

(Year)

AGE

5

yrs.

3

mos.

20

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)

Shannon Co Mo

PARENTS

NAME OF FATHER

Aaron A. Ball

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Texas Co Mo

MAIDEN NAME OF MOTHER

Virginia Neal

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Shannon Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Aaron A. Ball

(ADDRESS)

Fremont Mo

Filed

Spt 23

1914

Jas H Lewis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Sept 21st

(Month)

(Day)

1914

I HEREBY CERTIFY, that I attended deceased, from Sept 18, 1914, to Sept 21st, 1914, that I last saw her alive on Sept 21st, 1914, and that death occurred, on the date stated above, at 10⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:

Tonsillitis (Diphtheritic)

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

6 ds.

(Signed)

Dr. F. C. Estes

M. D.

Sept 23, 1914

(Address)

Bloomington, 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

Green Cemetery

DATE OF BURIAL

191

UNDERTAKER

ADDRESS

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*, *Sar-*

coma, 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.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY & IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms.

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

PLACE OF DEATH Ripley
County Kelly
Township _____
or _____
Village _____
or _____
City _____ (NO. _____ St.: _____ Ward _____)

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

Registration District No. 965 File No. 10
Primary Registration District No. 5989 Registered No. _____

FULL NAME Mary Ball

[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 S
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Sept 21
Month _____ Day _____ Year _____
Satisfactory Information Supplied.

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) _____

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 Oct 10 1914 J. H. Lewis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 21 1914
Month _____ Day _____ Year _____

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw him _____, 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.
(Signed) _____ M. D.
_____, 191____ (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 Green Cove DATE OF BURIAL _____ 191____

UNDERTAKER Edmer Green ADDRESS Fremont Mo

Original file, date SEP 22 1914 19____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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