

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**

1393

PLACE OF DEATH _____
 County Jasper Co.
 Township Marian Madison Registration District No. 408 File No. _____
 or _____
 Village _____ Primary Registration District No. 5-564 Registered No. 12
 or _____
 City Lawrence (NO. R D R St. _____ Ward _____)
 FULL NAME Lucinda J. Hickey

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u> <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Jan 31</u> 18 <u>33</u> (Month) (Day) (Year)		
AGE <u>81</u> yrs. <u>11</u> mos. <u>26</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

BIRTHPLACE
(City or town, State or foreign country) Crawfordsville, Ind.

PARENTS	NAME OF FATHER <u>Irndon Bolen</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Georgia</u>
	MAIDEN NAME OF MOTHER <u>Elizabeth McKey</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. J. C. Clauder
 (ADDRESS) 5 Sapulpa Okla
Lawrence, Mo
Jan 27 1915 W. E. Sule REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 27 1915
 (Month) 31 (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Jannayre, 1915, to Jan 26, 1915,
 that I last saw her alive on Jan 26, 1915,
 and that death occurred, on the date stated above, at 3 a.m.
 The CAUSE OF DEATH^t was as follows:

Foecal Impaction of Illium
1913
 (Duration) ___ yrs. ___ mos. ___ ds.
 Contributory (SECONDARY) _____
 (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. M. Anderson M. D.
Jan 27 1915 (Address) Carthage, 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>Stone Cemetery</u>	DATE OF BURIAL <u>Jan 28 1915</u>
UNDERTAKER <u>J. H. Guibart</u>	ADDRESS <u>Carthage, Mo</u>

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 (Write 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 business, or establishment in which employed (or employer)

(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) _____

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 above, at _____ m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

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

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Address) _____ M. D.

* 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 _____

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. OCCUPATIONS 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

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

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

County Jasper
Township Madison
Village _____
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. H 08 File No. _____
Primary Registration District No. 5564 Registered No. 12

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

FULL NAME

Lucinda J. Hickey

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan. 27, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, 19____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____,
that I last saw h. _____ alive on _____, 19____,

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

and that death occurred, on the date stated above, 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) _____

Focal Infection of Ileum.
Caused by Focal matter

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

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

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) _____

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas Taylor M. D.
Jan. 27, 1915 (Address) Carthage Mo.

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

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

(ADDRESS) _____

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 Jan 27 1915 W. C. Seal
REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 19____

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY Information Supplies

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the precise CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact description of OCCUPATION is very important. Subsequent copy at MOITAVD-378

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*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

1393

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.)