

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state their names and titles 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

1 PLACE OF DEATH

County Johnson
Township Jefferson
or Blue
Village Blue
or
City (NO. St. Ward)

Registration District No. 14 File No. 1534
Primary Registration District No. 5587 Registered No. 2

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

2 FULL NAME Mona May Morris

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

10 DATE OF DEATH Jan 25, 1915
(Month) (Day) (Year)

6 DATE OF BIRTH Dec 29, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended, deceased from Jan 22, 1915 to Jan 25, 1915, that I last saw her alive on Jan 25, 1915

7 AGE 1 mos. 4 ds. If LESS than 1 day, hrs. or min.?

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

8 OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer) None

Pneumonia
108
(Duration) yrs. mos. 2 ds.

9 BIRTHPLACE (City or town, State or foreign country) Bowen, Mo.

CONTRIBUTORY (Secondary)

10 NAME OF FATHER S. M. Morris

(Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Illinois

(Signed) J. A. Blackmore M. D.

12 MAIDEN NAME OF MOTHER Nannie Adams

Jan 26, 1915 (Address) Windsor, Mo.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) S. M. Morris

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

(Address) Bowen, Mo.

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.

15 Filed Jan 26, 1915 Registrar J. A. Blackmore

19 PLACE OF BURIAL OR REMOVAL Windsor, Mo. DATE OF BURIAL Jan 26, 1915

20 UNDERTAKER Windsor, Mo. ADDRESS Windsor, 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, 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), *20 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.)

PLACE OF BIRTH

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 Johnson

Township Jefferson

Village _____

City _____

Registration District No. 14

File No. _____

Primary Registration District No. 5587

Registered No. 2

(NO. _____)

St.: _____

Ward _____

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

FULL NAME Mona May Morris

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH

Apr. 2, 1915
(Month) (Day) (Year)

DATE OF BIRTH

1, _____, 1915
(Month) (Day) (Year)

AGE

If LESS than 1 day, _____ hrs. or _____ min.

HEREBY CERTIFY, that I attended deceased from _____, 1915, to _____, 1915, that I last saw h _____ alive on _____, 1915, and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows: 1. Pneumonia

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 Apr 10, 1915

REGISTRAR [Signature]

Contributory (SECONDARY) _____

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

(Signed) T. A. Blastner, M. D.

Apr 2, 1915 (Address) Underwood, 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 _____ DATE OF BURIAL _____

UNDERTAKER _____ ADDRESS _____

Original file, date _____ 19 _____

All information called for must be written on this Supplementary Certificate.

N. B.—Every item of information should be carefully checked. 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.

SATISFACTORY INFORMATION SUPPLIED

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1534

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