

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

PLACE OF DEATH

County Butler

Township _____

or Village Keelyville

or City _____ (NO. _____)

Registration District No. 58

Primary Registration District No. 575
1054

File No. 3928

Registered No. 19

St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Georgia Smith

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

SEX

Female

COLOR OR RACE

Black

SINGLE MARRIED married
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

Jan 31st
(Month) (Day) (Year) 1915

DATE OF BIRTH

About Jan 31st
(Month) (Day) (Year) 1888

I HEREBY CERTIFY, that I attended deceased from

Jan 7, 1915, to Jan 31, 1915,
that I last saw h alive on Jan 28, 1915,

AGE About 27 years
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Pernicious
Malarial Fever
37

OCCUPATION

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(Duration) 3 yrs. 04 mos. ds.

BIRTHPLACE

(City or town, State or foreign country) Missouri

Contributory

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

NAME OF FATHER

Robert Allen

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

Feb 2nd 1915 (Address) Keelyville

BIRTHPLACE OF FATHER

Missouri

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

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) Nancy Smith

(ADDRESS) Keelyville 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

PLACE OF BURIAL OR REMOVAL

At Keelyville Mo

DATE OF BURIAL

Feb 2, 1915

UNDERTAKER

Poplar Bluff Mo

ADDRESS

Filed Feb 2 1915 W B Davis

REGISTRAR

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.

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

use of "Tumor" for malignant neoplasma); *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.)

PLACE OF DEATH

County Butler

Township or Village or City Neelyville

Registration District No. 88 File No. _____

Primary Registration District No. 4054 Registered No. 19

City _____ (NO. _____) _____ (St. _____) Ward _____

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

FULL NAME

Georgia Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE R. SINGLE MARRIED WIDOWED OR DIVORCED M.
(Write the word)

DATE OF DEATH Jan 31, 1915
(Month) (Day) (Year)

DATE OF BIRTH Sept 10, 1870
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h. _____ alive on _____, 191____,

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day _____ hrs. or _____ 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) _____

Satisfactory Information Supplied.

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

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

NAME OF FATHER _____

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

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

(Signed) _____ M. D.
_____ 191____ (Address) _____

MAIDEN NAME OF MOTHER unknown

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS):
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death? _____

(Informant) Ms Smith
(ADDRESS) Neelyville Mo.

Former or usual residence _____

Filed Jan 4, 1915 W B Davis

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

REGISTRAR

UNDERTAKER _____ ADDRESS _____

called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

PAGE 11 of 11. Every effort should be made to classify. If not classified, be careful that it is not misclassified. CAUSE OF DEATH

Revised United States Standard Certificate of Death

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

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