

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

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

County Douglas

Township Bryan

Village Buckhart

City _____

Registration District No. 176

Primary Registration District No. 5393

File No. 8060

Registered No. 6

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

FULL NAME

Polly Sims

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE Widowed
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

Aug 28, 1896
(Month) (Day) (Year)

AGE

79 yrs. 8 mos. ds. If LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

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

At Home

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

BIRTHPLACE

(City or town, State or foreign country)

Tenn

PARENTS

NAME OF FATHER

John Wilton

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Tenn

MAIDEN NAME OF MOTHER

Margaret Robertson

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. S. Sims

(ADDRESS)

Buckhart Mo

Filed

Mar 10 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar 9, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from No Physician, 1915,
that I last saw him alive on attendance,
and that death occurred, on the date stated above, at 2:30 A.M.
The CAUSE OF DEATH* was as follows:
Paralysis
82.D

(Duration) 7 yrs. 7 mos. ds.

Contributory

Paraplegia

(Signed) Chas. J. Sims

(Duration) 8 mos. ds.

(Signed) location

(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

Fedrick Cemetery

DATE OF BURIAL

Mar 10 1915

UNDERTAKER

Columbus Tooley

ADDRESS

Buckhart

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 PERMANENT RECORD

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PLACE OF DEATH		REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.		BUREAU OF VITAL STATISTICS	
COUNTY		CITY		CERTIFICATE OF DEATH	
Douglas		Bryan		276	
Township		Registration District No.		File No.	
or		Primary Registration District No.		Registered No.	
Village		5393		6	
or		St.		Ward)	
City		NO.		(If death occurred in a hospital or institution, give its NAME instead of street and number)	
FULL NAME <i>Pally Sims</i>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <i>M</i>	COLOR OR RACE <i>W</i>	SINGLE MARRIED WIDOWED OR DIVORCED (If wife the word)	DATE OF DEATH <i>Mar 9</i>		
DATE OF BIRTH			HEREBY CERTIFY, that I attended deceased from		
(Month) (Day) (Year)			191 (Month) (Day) (Year)		
AGE			that I last saw him alive on		
10 yrs. mos. ds.			191 (Month) (Day) (Year)		
OCCUPATION			and that death occurred, on the date stated above, at		
(a) Trade, profession, or particular kind of work			The CAUSE OF DEATH* was as follows:		
(b) General nature of industry, business, or establishment in which employed (or employer)			<i>Paralysis Paraplegia</i>		
BIRTHPLACE			<i>unknown</i>		
(City or town, State or foreign country)			(Duration) yrs. mos. ds.		
PARENTS	NAME OF FATHER		Contributory		
	BIRTHPLACE OF FATHER		(SECONDARY)		
	MAIDEN NAME OF MOTHER		(Duration) yrs. mos. ds.		
	BIRTHPLACE OF MOTHER		(Signed) <i>No Phy is an in</i>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			(Address) <i>Allen dance</i>		
(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)		
3/10 1915 <i>S. M. True</i>			At place of death		
REGISTRAR			In the State yrs. mos. ds.		
Original file, date			Where was disease contracted if not at place of death?		
1915			Former or usual residence		
All information called for must be written on this Supplementary Certificate.			PLACE OF BURIAL OR REMOVAL		
			<i>Bedien N. Ceme</i>		
			DATE OF BURIAL		
			<i>Mar 10 1915</i>		
			UNDERTAKER		
			<i>McColumbus Tooly Buckhart</i>		
			ADDRESS		

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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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.)