

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

1 PLACE OF DEATH

County Bronx Registration District No. 76 File No. 11609
Township Declar or Village Primary Registration District No. 5110 B Registered No. 1
City (NO. St. Ward)

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

2 FULL NAME Diary Ballard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE American 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
6 DATE OF BIRTH Oct. 4 1847
(Month) (Day) (Year)
7 AGE 67 yrs. 4 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)

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

PARENTS
10 NAME OF FATHER Joe Wilson
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Va.
12 MAIDEN NAME OF MOTHER Rachel Thomas
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Gen. Ballard
(Address) Blaynselle

15 Filed April 9 1915 B. C. Pamer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 9 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 1st 1915 to April 9 1915
that I last saw her alive on April 9 1915
and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH was as follows:
Lobar Pneumonia
23 A
108
(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) tuberculosis
about (Duration) 4 yrs. mos. ds.
(Signed) _____ M. D.
, 1915 (Address)

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

18 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

19 PLACE OF BURIAL OR REMOVAL W. Pleasant DATE OF BURIAL April 11 1915
20 UNDERTAKER A. P. Hanley & Son Ashland Mo. ADDRESS

N. B.—Every CAUSE OF DEATH must be stated.

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*, *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), *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.)

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH.

County Boone
Township Cedar
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 16 File No. _____
Primary Registration District No. 5110 B Registered No. 4

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

FULL NAME Deey Ballard

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Apr. 9, 1915
(Month) (Day) (Year)

DATE OF BIRTH Satisfactory Information Supplied
(Month) (Day) (Year)

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

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

The CAUSE OF DEATH was as follows:
Robert pneumonia

OCCUPATION _____
Trade, profession, or particular kind of work _____
General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____
City or town, State or foreign country

(Duration) _____ yrs. _____ mos. 9 ds.
Contributory Tuberculosis of Lungs
(SECONDARY) _____ (Duration) 4 yrs. _____ mos. _____ ds.

NAME OF FATHER _____

(Signed) O. Warner M. D.
Apr 9 1915 (Address) Hartington Mo.

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

MAIDEN NAME OF MOTHER _____

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

*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.

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

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

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL W. Democrat DATE OF BURIAL Apr 11 1915

Filed Apr 19 1915 O. Warner REGISTRAR

UNDERTAKER H.P. Bailey ADDRESS W. Democrat

SUPPLEMENTARY

Satisfactory Information Supplied

N. B.—Excess of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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[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.)