

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. 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**

PLACE OF DEATH
 County Jackson
 Township Prairie Registration District No. 397 File No. 12492
 or Greenwood Primary Registration District No. 5557B Registered No. 31
 or Greenwood City (NO. _____) St. _____ Ward _____

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

FULL NAME Syvilla L. Harris

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH Aug 3 1903
(Month) (Day) (Year)

AGE 11 yrs. 7 mos. 23 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Greenwood, MO

NAME OF FATHER D. B. Harris

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

MAIDEN NAME OF MOTHER Sarah Emma Hutchins

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) D. B. Harris

(ADDRESS) Greenwood, Mo

Filed 4-12 1915 W. L. Schick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 11 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 10 1915, to Apr. 11 1915, that I last saw her alive on Apr. 11 1915, and that death occurred, on the date stated above, at 5:30 a.m.
 The CAUSE OF DEATH* was as follows:

Peritonitis
129 (Duration) 11 yrs. 2 mos. 2 ds.

Contributory Gastro-enteritis
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. B. Swaney M. D.
Apr. 11 1915 (Address) Lee's Summit, MO

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR (CENT 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 Lee's Summit DATE OF BURIAL April 12 1915

UNDERTAKER W. L. Schick ADDRESS Lee's Summit 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.

Examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The work on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," etc., without more precise specification, as *Day laborer, Laborer—Coal mine*, etc. Women are engaged in the duties of the household (as *Housekeepers* who receive a definite salary), as *Housewife, Housework*, or *At home*, and fully employed, as *At school* or *At home*. Men to report specifically the occupations in domestic service for wages, as *Servant*, etc. If the occupation has been in account of the DISEASE CAUSING at beginning of illness. If fact may be indicated thus: or persons who have no occu-

death.—Name, first, the primary affection with re- using always the same ase. Examples: *Cerebrum* is "Epidemic meningitis" (avoid use of "Typhoid pneumonia" ("Pneumonia of lungs, coma, etc. of finite; 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," "Quarantine," "Shock," "Uraemia," "Weakness," etc., when 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 INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL. For as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck 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 American Medical Association.)

As
(b)
mater
ment.
"Dealer,
laborer, Fa.
at home, wh
only (not paid
may be entered
children, not gain.
Care should be tak
of persons engaged
vant, Cook, Houseman
changed or given up o.
DEATH, state occupation
tired from business, that
Farmer (retired, 6 yrs.) Fe
pation whatever, write None

Statement of cause of
DISEASE CAUSING DEATH (the p
spect to time and causation),
accepted term for the same dise
cerebrospinal fever (the only definite sy
cerebrospinal meningitis"); *Diphthe*
"Croup"); *Typhoid fever* (never repor
monia"); *Lobar pneumonia*; *Bronchopne*
monia," unqualified, is indefinite); *Tuber*
meninges, *peritonaeum*, etc., *Carcinoma*, *Sa*
name origin.