

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Meriwether
Township Paranna
or
Village
or
City

Registration District No. 557 File No. 13392

Primary Registration District No. 5751 Registered No.

(NO. St. Ward)

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

2 FULL NAME

Leona Jett Nelson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Wh</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>single</u>
6 DATE OF BIRTH <u>Sept 25 1913</u> (Month) (Day) (Year)		
7 AGE <u>1 yrs 6 mos 26 ds.</u>		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>V</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>V</u>		
9 BIRTHPLACE (City or town, State or foreign country) <u>Oklahoma</u>		
PARENTS	10 NAME OF FATHER <u>H. L. Nelson</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Okla.</u>	
	12 MAIDEN NAME OF MOTHER <u>Viola Barker</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

3 MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from
Apr 11 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 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute indigestion
179A
118C
(Duration).....yrs.....mos.....2 ds.

CONTRIBUTORY
(Secondary)
(Duration).....yrs.....mos.....ds.

(Signed) N. A. Smith M. D.
Apr 12 1915 (Address) Paranna Mo.

*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
Newtown Mo. DATE OF BURIAL
Apr 12 1915

20 UNDERTAKER
H. C. Brantley ADDRESS
Paranna Newtown Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Callen
(Address) Newtown Mo.

15 Filed Apr 12 1915 J. L. Douthett Registrar

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of

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.)

PLACE OF DEATH

County

Meru
Ravanna

Township

Registration District No.

557

File No.

Village

Primary Registration District No.

5751

Registered No.

City

(No.

St.

Ward)

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

FULL NAME

Lena Jett Nelson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

S

DATE OF DEATH

(Month)

(Day)

(Year)

Apr 11 1915

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

IF LESS than 1 day, ___ hrs. or ___ min. yrs. mos. ds.

I HEREBY CERTIFY, that I attended deceased from *1915* satisfactory information supplied, that I last saw h *alive on* *1915*

and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Indigestion
Cholera Infantum

(Duration)

yrs.

mos.

ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

N. A. Smith M.D.
Apr 12 1915 (Address) *Ravanna*

*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

in the

State

yrs.

mos.

Where was disease contracted if not at place of death

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

Apr 12 1915
J. S. Ditzfener
REGISTRAR

Original file, date _____, 19__

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

N. B.—Every item of information should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be supplied. AGE should be given EXACTLY. OCCUPATION is very important.

Supplementary Information Supplied

Supplementary Information Supplied

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

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