

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

PLACE OF DEATH

County Johnson Registration District No. 430 File No. 10867
Township East Oak or Village Lorton Primary Registration District No. 4284 Registered No. 75
City (NO. _____) St. _____ Ward _____

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

FULL NAME Geraldine Ruth Noland

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Aug 7, 1910</u> (Month) (Day) (Year)	AGE <u>1</u> yrs. <u>6</u> mos. <u>26</u> ds. If LESS than 1 day, _____ hrs. or _____ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		
PARENTS	NAME OF FATHER <u>J. W. Noland</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>H. V. Velman</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Noland
(ADDRESS) Chelkover Mo
Filed Mar 7 1916 R. P. Kosus REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 5, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 22, 1916, to March 5, 1916, that I last saw her alive on March 5, 1916, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:
Fungus of foot

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

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

(Signed) J. R. Hampton M. D.
Mar 7 1916 (Address) East Oak

*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 1 yrs. 6 mos. 26 ds. In the _____ State 1 yrs. 6 mos. 26 ds.
Where was disease contracted if not at place of death? Place of death

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Providence DATE OF BURIAL Mar 6 1916

UNDERTAKER Neighborhood ADDRESS East Oak

WRITE FAIRLY, 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.

MARGIN RESERVED FOR

V. S. NO. 1.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. The cause of death should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statements of occupation should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of occupation should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

1 PLACE OF DEATH

County Johnson
 Township Lecton
 or
 Village Lecton
 or
 City Lecton (NO. St. Ward)

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

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

Registration District No. 430 File No.
 Primary Registration District No. 4286 Registered No. 73

2 FULL NAME

Geraldine Ruth Roland

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>S.</u> (Write the word)
6 DATE OF BIRTH <u> </u> (Month) <u>1</u> (Day) <u>191</u> (Year)		
7 AGE <u> </u> yrs. <u> </u> mos.		If LESS than 1 day, <u> </u> hrs. or <u> </u> min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u> </u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u>		
9 BIRTHPLACE (City or town, State or foreign country) <u> </u>		
PARENTS	10 NAME OF FATHER <u> </u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u> </u>	
	12 MAIDEN NAME OF MOTHER <u> </u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u> </u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
3 / 15 / 1916
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1916, to 1916, that I last saw h alive on 1916, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* was as follows:
Cholera followed by
lung trouble of foot & leg
toe with whole foot
engorged beyond death
 (Duration) yrs. mos. ds.

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

(Signed) J. R. Hartman M. D.
3/15/16 (Address) Post Oak 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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant)
 (Address)

15 Filed Mar 7 1916 R. P. Koons
 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 1916

20 UNDERTAKER ADDRESS

Original file, date , 1916

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

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), 29ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthénia," "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 septichaemia," "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.)

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