

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

PLACE OF DEATH

County Nodaway

Township Morris

or Village Skidmore

or City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 630

File No. 22094

Primary Registration District No. 5832

Registered No. _____

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

FULL NAME Vienna Bernice Shipp

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Girl COLOR OR RACE White SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH April 2, 1916
(Month) (Day) (Year)

DATE OF BIRTH March 1, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 25, 1916, to April 1, 1916, that I last saw her alive on April, 1916, and that death occurred, on the date stated above, at 8 a m.

AGE 1 yrs. 1 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Cerebro spinal meningitis
(non-lepid)

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) 18

(Duration) ___ yrs. ___ mos. ___ ds.

BIRTHPLACE (City or town, State or foreign country) Nodaway Co

(Duration) ___ yrs. ___ mos. ___ ds.

PARENTS NAME OF FATHER Ina Dwight Shipp BIRTHPLACE OF FATHER (City or town, State or foreign country) Morris Co Mo. MAIDEN NAME OF MOTHER Ethel May King BIRTHPLACE OF MOTHER (City or town, State or foreign country) Adrian Co Mo.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. C. Manning M. D. June 10, 1916 (Address) Skidmore

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) V. L. Shipp (ADDRESS) Skidmore Mo

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 _____

Filed June 16, 1916 J. C. Manning REGISTRAR

PLACE OF BURIAL OR REMOVAL Masonic Cemetery DATE OF BURIAL April 4, 1916

UNDERTAKER W. D. Dadds ADDRESS Skidmore Mo

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.

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*, *Composer*, *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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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

1 PLACE OF DEATH
 County Madison
 Township Monroe
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 630 File No. _____
 Primary Registration District No. 5832 Registered No. _____

2 FULL NAME Verna Bernice Shipps

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F **4 COLOR OR RACE** W. **5 SINGLE MARRIED WIDOWED OR DIVORCED** S
(Write the word)

6 DATE OF BIRTH _____ (Month) _____ (Day) 1 _____ (Year)

7 AGE _____ yrs. _____ mos. _____ ds. **If LESS than 1 day** _____ hrs. _____ min.?

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

9 BIRTHPLACE
 (City or town, State or foreign country) _____

10 NAME OF FATHER _____
11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____
12 MAIDEN NAME OF MOTHER _____
13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

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

15 Filed June 10 1916 J. B. Manning
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH _____ 191_____.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 191_____.
 to _____ 191_____.
 that I last saw him _____ 191_____.
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Cerebro spinal Meningitis
 (Duration _____ yrs. _____ mos. _____ ds.)

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

(Signed) J. B. Manning M.D.
6-10-1916 (Address) Shiloh, 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 _____ DATE OF BURIAL _____ 191_____.

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

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

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22094
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