

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

1 PLACE OF DEATH
County Franklin
Township Boles Registration District No. 293 File No. 24101
or Walla Ridge Primary Registration District No. 5411 Registered No. 34
Village Walla Ridge
or
City (NO. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sibba Wooten

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>F</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>widowed</u>		10 DATE OF DEATH <u>July 8</u> , 191 <u>6</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Jan. 6</u> , 18 <u>36</u> (Month) (Day) (Year)				17 I HEREBY CERTIFY, that I attended deceased from <u>June 1</u> , 191 <u>6</u> , to <u>July 8</u> , 191 <u>6</u> , that I last saw her alive on <u>July 8</u> , 191 <u>6</u> , and that death occurred, on the date stated above, at <u>9:10</u> a.m.	
7 AGE <u>80</u> yrs <u>6</u> mos <u>2</u> ds.		If LESS than 1 day, ... hrs. or ... min.?		The CAUSE OF DEATH* was as follows: <u>83 Paralysis</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housework</u> (b) General nature of industry business, or establishment in which employed (or employer)				(Duration) <u>3</u> yrs. mos. ds.	
9 BIRTHPLACE (City or town, State or foreign country) <u>North Carolina</u>				CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.	
PARENTS	10 NAME OF FATHER <u>Jacob Black</u>			(Signed) <u>J. P. Deane</u> , M. D.	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>North Carolina</u>			7-8, 191 <u>6</u> . (Address) <u>Walla Ridge</u>	
	12 MAIDEN NAME OF MOTHER <u>Sarah Miller</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Do not know</u>				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) <u>Owen Wooten</u> (Address) <u>Catawissa Mo</u>				19 PLACE OF BURIAL OR REMOVAL <u>Pacific City Cemetery</u> DATE OF BURIAL <u>7-9</u> , 191 <u>6</u>	
15 Filed <u>July 8</u> , 191 <u>6</u> <u>H. A. Booth</u> Registrar				20 UNDERTAKER <u>Geo. A. Thibbes</u> ADDRESS <u>Pacific Mo</u>	

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*, *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*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, 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 "Asthemia," "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.)

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

PLACE OF DEATH
 County Franklin
 Township Bolis
 or
 Village
 or
 City

Registration District No. 293 File No.
 Primary Registration District No. 5411 Registered No. 31
 St. Ward

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

2 FULL NAME Selma Woster

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH July 8 1916
 (Month) (Day) (Year)

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

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

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

Supplementary Information Supplied
 The CAUSE OF DEATH* was as follows:
Paralysis
General Paralysis of the Insane

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)

(Duration) 3 yrs. 6 mos. 9 ds.

10 NAME OF FATHER

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

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

(Signed) 7/8 1916 (Address) 7, P. Avenue, M. D. Williams, Mo.

12 MAIDEN NAME OF MOTHER

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death, yrs. mos. ds. In the State yrs. mos. ds. of death.

(Informant)

Where was disease contracted if not at place of death?

(Address)

Former or usual residence

15 Filed 7/8 1916 H. A. Booth Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
 1916

20 UNDERTAKER ADDRESS

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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 "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.)

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