

## 1 PLACE OF DEATH

County CarrollMISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Township .....

Registration District No. 135File No. 30632

or

Village .....

Primary Registration District No. 3010Registered No. 76

or

City Carrollton (NO. ....)

St. .... Ward)

2 FULL NAME

Lucie A. Perkins

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

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow6 DATE OF BIRTH October 8 1872  
(Month) (Day) (Year)7 AGE 73 yrs. 10 mos. 18 ds. If LESS than 1 day.....hrs. or.....min.?8 OCCUPATION (a) Trade, profession, or particular kind of work House wife 23A 8718 162  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (City or town, State or foreign country) Carroll Co. Mo.PARENTS 10 NAME OF FATHER Henry O. Roy  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Va.  
12 MAIDEN NAME OF MOTHER Mary M. Rogers  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. K. Turner(Address) Carrollton, Mo.

15

Filed Sept 7 1916 Ms. E. E. Jamison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 5 1916  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from 4th May 1916 to 25 Aug. 1916  
that I last saw her alive on 23rd June 1916  
and that death occurred, on the date stated above, at 8<sup>00</sup> P. m.

The CAUSE OF DEATH\* was as follows:

Don't know - Nervous  
Complication of probably 40 years standingCONTRIBUTORY Influenza  
(Secondary) Several (Duration) yrs. mos. ds.Signed H. W. Hull M. D.  
7th Sept. 1916 (Address) Carrollton 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 Oak Hill Cem. DATE OF BURIAL Sept 8 191620 UNDERTAKER J. E. Willis ADDRESS Carrollton, 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, 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 "*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.)

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

1 PLACE OF DEATH  
*Carroll*  
County  
Township  
or  
Village  
or  
City

Registration District No. *135* File No.

Primary Registration District No. *3010* Registered No. *76*

2 FULL NAME *Lucie A. Perkins*

(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 *W*  
(Write the word)

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

7 AGE  
yrs. mos. ds. If LESS than 1 day hrs. or 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 *Sept. 13, 1916* *Mrs E. E. Farnham*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept. 5, 1916*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from the 1st saw him alive to

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Don't know. Nervous. Complication - probably tuberculosis*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Transition*

(Duration) yrs. mos. ds.

(Signed) *H. W. Sull* M. D.

*9/7, 1916* (Address) *Carrollton, Mo.*

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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

1916

20 UNDERTAKER ADDRESS

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