

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

33641

1 PLACE OF DEATH

County Butler

Township Blackriver

Village _____

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

Registration District No. 91

File No. _____

Primary Registration District No. 5731 Registered No. 10

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

2 FULL NAME

Ollie Bell Mills

PERSONAL AND STATISTICAL PARTICULARS

3 SEX girl 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Oct July 13 1915
(Month) (Day) (Year)

7 AGE 1 yrs 3 mos 12 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) Poplar Bluff Mo.

10 NAME OF FATHER Harry Wiggins

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

12 MAIDEN NAME OF MOTHER Anna Wells

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Wells
(Address) Kaener, Mo.

15 Filed Oct 13, 1916 Jacob Wells Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 12 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 10 1916 to Oct 12 1916, that I last saw her alive on Oct 12 1916, and that death occurred, on the date stated above, at 11:10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

(Duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY Dysentery
(Secondary) (Duration) _____ yrs. _____ mos. 5 ds.

(Signed) Jacob Wells M. D.
Oct 13 1916 (Address) Hardy St. 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 Military Cem. DATE OF BURIAL Oct 13, 1916

20 UNDERTAKER Wells ADDRESS _____

Re 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; 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 "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.)

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.

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

1 PLACE OF DEATH
Butler
Blackriver

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

Registration District No. *91* File No. _____
Primary Registration District No. *5135* Registered No. *10*

FULL NAME (NO. _____ St. _____ Ward _____)
Ollie Bell Wells. [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 _____ 1 _____ 191____
(Month) (Day) (Year)

7 AGE _____
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) _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct, 12 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:
Cerebral Meningitis (Septic)
(Duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY *Dysentery.*
(Secondary) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *J. Lee Harwell* M. D.
10/13/16 (Address) *Hendrickson, 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

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

15 Filed *Oct 13, 1916* *J. Lee Harwell*
Registrar

Revised United States Standard Certificate of Death

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

33641

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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), *29ds.*; *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 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.)