

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

1 PLACE OF DEATH

County *Davies*

Township _____

or Village _____

or City *Yanagin*

Registration District No. *250*

File No. *731*

Primary Registration District No. *4150*

Registered No. *16*

(NO. _____ St. _____ Ward _____)

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

2 FULL NAME *Mary Elizabeth Myers*

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *married*

10 DATE OF DEATH *January 29, 1917*
(Month) (Day) (Year)

6 DATE OF BIRTH *Dec 25, 1850*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *January 28, 1917* to *January 29, 1917*

7 AGE *67* yrs. *1* mos. *4* ds. If LESS than 1 day, hrs. or min.?

that I last saw him alive on *Jan 28, 1917* and that death occurred, on the date stated above, at *8 P.M.*

The CAUSE OF DEATH* was as follows:
Decomposition uraemic

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

9 BIRTHPLACE (City or town, State or foreign country) *Davies Mo*

CONTRIBUTORY (Secondary) *old age*
(Duration) yrs. mos. ds.

10 NAME OF FATHER *Nathan Shelley*

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

12 MAIDEN NAME OF MOTHER *Don't know*

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

(Signed) *B. E. Light* M. D.
Jan 30, 1917 (Address) *Ballston*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *R. J. Myers*
(Address) *Kansas City*

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

15 Filed *Jan 30, 1917* *W. B. Brown* Registrar

19 PLACE OF BURIAL OR REMOVAL *Leukmore Ave* DATE OF BURIAL *Jan 31, 1917*

20 UNDERTAKER *L. Killam* ADDRESS *Gallatin Mo*

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, 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.)

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

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Registration District No.

250

File No.

Village

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16

City

Gallatin

(NO.

St.

Ward)

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

2 FULL NAME

Mary Elizabeth Myers

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH
 (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)

PARENTS
 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 *Jan 30 1917*
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jan 29 1917
 (Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
*Paris - Uræmia
 nephritis Chronic
 and ap 170*

CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) *W. H. Brooks* M. D.
Jan 30 1917 (Address) *Gallatin, Md.*

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 20 UNDERTAKER ADDRESS

SUPPLEMENTARY INFORMATION SUPPLEMENTARY INFORMATION SUPPLEMENTARY INFORMATION

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