

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

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

Registration District No. 579 File No. 2218
Primary Registration District No. 5776B Registered No. _____

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

2 FULL NAME Susan J. Lightner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 SINGLE MARRIED WIDDED OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Sept 24 1887
(Month) (Day) (Year)

7 AGE 79 yrs 3 mos 28 ds If LESS than 1 day, hrs. or min.?

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

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

PARENTS
10 NAME OF FATHER William Madson
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Idy 8
12 MAIDEN NAME OF MOTHER Don't know
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Higgins
(Address) Sturgeon Mo

15 Filed 1/22 1917 F. L. Thompson Deputy
Waller W. E. Shaw (Registrar)

2) MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 22 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 17th 1917 to Jan 22nd 1917
that I last saw her alive on Jan 21st 1917
and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Paralysis
92 A
82 A

(Duration) yrs. mos. ds. 3
CONTRIBUTORY Mitral Regurgitation
(Secondary) Flow
(Duration) yrs. mos. ds.
(Signed) M. C. Prusky M. D.
Jan 23rd 1917 (Address) Madison Mo

*State the Disease Causing Death, or, in death 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 Holiday DATE OF BURIAL Jan 23 1917

20 UNDERTAKER Fred A. Thompson ADDRESS Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO)

St.

Ward

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

5 SINGLE
MARRIED
OR DIVORCED
OR WIDOWED
(Write the word)

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)

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

191

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, that I attended deceased for

191

to

191

that I last saw h..... alive on

191

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

in

The CAUSE OF DEATH* was as follows:

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Address)

M. D.

*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

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state carefully the nature of the disease.

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

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

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

Registration District No. 579 File No.
Primary Registration District No. 5776-B Registered No.

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

2 FULL NAME Susan J Lightner

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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 X 191... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
(Month) (Day) (Year)
Jan 22 1917

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:
Paralysis
of the motor nerves of the brain
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
Metal Rigidity of the
(Duration) yrs. mos. ds.
(Signed) Jan 23 1917 M. D.
(Address) Madison

*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

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, if 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);

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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 inter-
current) 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), "Atro-
phy," "Collapse," "Coma," "Convulsions," "De-
bility" ("Congenital," "Senile," etc.), "Dropsy,"
"Exhaustion," "Heart failure," "Haemorrhage,"
"Inanition," "Marasmus," "Old age," "Shock,"
"Uraemia," "Weakness," etc., when a definite dis-
ease can be ascertained as the cause. Always qualify
all diseases resulting from childbirth or miscarriage,
as "PUERPERAL septicaemia," "PUERPERAL perito-
nitis," 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 de-
termine 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." (Recom-
mendations on statement of cause of death approved
by Committee on Nomenclature of the American
Medical Association.)