

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH:

1 PLACE OF DEATH

County

*Newton*  
*Berwick*

Township

Registration District No.

*412*

File No.

*52329*

Village

Primary Registration District No.

*6257*

Registered No.

*5*

City

(NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

2 FULL NAME

*Marcy Shipman*

PERSONAL AND STATISTICAL PARTICULARS

*3*

MEDICAL CERTIFICATE OF DEATH

3 SEX

*F.*

4 COLOR OR RACE

*W.*

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

*Married*

16 DATE OF DEATH

*Jan. 21 1917*  
(Month) (Day) (Year)

6 DATE OF BIRTH

*Aug 29 1832*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from

*Jan. 17 1917 to Jan. 21 1917*

7 AGE

*84*

If LESS than 1 day, hrs. or min.?

that I last saw him alive on *1917*

and that death occurred, on the date stated above, at *11 P.M.*

The CAUSE OF DEATH\* was as follows:

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*House wif*

(b) General nature of industry business or establishment in which employed (or employer)

*Housewife*

*accidentally injured  
18 1/2 A. (Broken leg)  
194; B (Duration) yrs. mos. 01 ds.*

9 BIRTHPLACE

(City or town, State or foreign country)

*Missouri*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

PARENTS

10 NAME OF FATHER

*Sampson Looney*

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

*Missouri*

12 MAIDEN NAME OF MOTHER

*Sarah Hunt*

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

*Illinois*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*M. G. Shipman*  
*Peirce City, 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

15

Filed

*Jan 22, 1917*

*D. F. Ziegler M.D.*  
*Registrar*

19 PLACE OF BURIAL OR REMOVAL

*Murphy Cemetery*

DATE OF BURIAL

*Jan 2, 1917*

20 UNDERTAKER

*H. Bennett Peirce City, Mo.*

ADDRESS

N. B.—Every CAUSE should be stated EXACTLY. PHYSICIANS should state 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, 8 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, 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), *20 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

PLACE OF DEATH  
 County Newton  
 Township Berwick  
 Village  
 City

Registration District No. 612 File No. 2329  
 Primary Registration District No. 6257 Registered No. 5  
 (NO. St. Ward)

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

FULL NAME Nancy Shipman

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH  
 (Month) (Day) 1 (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 Jan 22 1917 B. F. Lazubynski Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 21 1917  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1917 to 1917  
 that I last saw h..... alive on ..... 1917  
 and that death occurred, on the date stated above at .....

The CAUSE OF DEATH\* was as follows:  
Accidentally Injured  
Head, Neck, Shoulder, Hand, Injury  
Broken leg  
Alcohol and fall of  
 (Duration) yrs. mos. ds. 5

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

(Signed) E. B. Wright M.D.  
Jan 22 1917 (Address) Pure City, Mo.

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

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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

20 UNDERTAKER ADDRESS

SUPPLEMENTARY

7 item of information should be carefully supplied. AGE, etc. must be fully supplied. AGE, etc. must be fully supplied. Exact statement on OF DEATH in plain terms, so that it may be properly classified. Exact statement on

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