

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
County Rufous
Township 6
Village
City (NO. _____ St. _____ Ward _____)

Registration District No. 719 File No. 2618-D
Primary Registration District No. 5350 Registered No. _____

2 FULL NAME Mattie Gene Williams

(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 single
(Write the word)

6 DATE OF BIRTH January 25, 1917
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
yrs. _____ mos. 5 ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

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

10 NAME OF FATHER Biley Williams

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

12 MAIDEN NAME OF MOTHER Helen Collins

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

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 30, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw her alive on January 5, 1917
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
151
Premature Birth
1.59 (Duration) yrs _____ mos. 5 ds.
CONTRIBUTORY Premature Birth
(Secondary) (Duration) yrs _____ mos. _____ ds.
(Signed) E. G. Thomas M. D.
Jan 30, 1917 (Address) Washington

*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 _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Williams
(Address) Livonia

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL Jan 31, 1917

15 Filed Jan 31, 1917 John Pickering
Registrar

20 UNDERTAKER Baker ADDRESS Livonia

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, 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), *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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

1 PLACE OF DEATH
County Pettis
Township Elea
Village _____
City _____

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

CERTIFICATE OF DEATH

Registration District No. 719 File No. _____
Primary Registration District No. 5450 Registered No. _____
St. _____ Ward _____

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

2 FULL NAME Nettie Irene Williams

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE _____
If LESS than 1 day... hrs. or... min.?
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 5/6 1917 John Pickering Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jun 30 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 1917 to _____ 1917,
that I last saw him alive on _____ 1917,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) _____ M. D.
_____ 1917 (Address)

*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 Woods cemetery DATE OF BURIAL Jan 31 1917
20 UNDERTAKER John Baker ADDRESS Linn Mo

Revised United States Standard Certificate of Death

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

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keep;
as
not
Car

Missouri

MO.

HEALTH

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), "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"

State cause for which surgical operation undertaken. For VIOLENT DEATHS state means by and qualify as ACCIDENTAL, SUICIDAL OR AL, or as probably such, if impossible to definitely. Examples: *Accidental drowning; Railway train—accident; Revolver wound of suicide; Poisoned by carbolic acid—probably*. The nature of the injury, as fracture of consequences (e. g., *sepsis, tetanus*) may be under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Association.)

U. S. FORM XXX

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);