

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

1 PLACE OF DEATH

County *Andrew*

Township
or
Village
or
City *Medic Mo. Mexico Hospital*

Registration District No. *26*
Primary Registration District No. *3002*

File No. *4561*
Registered No. *27*

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

2 FULL NAME *Armstrong Pauline*

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE *71* yrs. *X* mos. *X* ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *West Va*

PARENTS
10 NAME OF FATHER *Armstrong Pauline*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Can't say*
12 MAIDEN NAME OF MOTHER *Can't say*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Can't say*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *J. Anderson*
(Address) *Drum Col.*

15 Filed *3346 West 8 av*
Feb 20, 1917 *Wallace Pearson*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb 21, 1917*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Feb 3* 1917 to *Feb 21* 1917, that I last saw him alive on *Feb 20* 1917, and that death occurred, on the date stated above, at *2 A* m.

The CAUSE OF DEATH* was as follows:
Gravel, Incontinence

(Duration) yrs. mos. ds.
CONTRIBUTORY *Cardiac Nephritis*
(Secondary)

(Signed) *Trud Luffen* M. D.
Feb 21, 1917 (Address) *Medic 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 *Mexico Mo* DATE OF BURIAL *Feb 20, 1917*

20 UNDERTAKER *H. H. Precht* ADDRESS *Mexico 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*, *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, 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Cadron

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

Township _____

Registration District No. 26

File No. _____

Village _____

Primary Registration District No. 3002

Registered No. 27

City Mexico

(NO. _____ St. _____ Ward _____)

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

2 FULL NAME

Armstrong Rankie

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Feb 21 1917
(Month) (Day) (Year)

6 DATE OF BIRTH _____ (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.

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

The CAUSE OF DEATH was as follows:

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

Faculty Professor
Chronic tubercular nephritis

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

Duration _____ yrs. _____ mos. _____ ds.
India nephritis

10 NAME OF FATHER _____

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

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

(Signed) Tred Suffer M. D.

12 MAIDEN NAME OF MOTHER _____

_____ 191____ (Address) _____

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

*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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

(Informant) _____

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(Address) _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

Filed 2/22 1917 Wallas Darling Registrar

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]

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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 "Asthénia," "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.)

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