

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

PLACE OF DEATH

County Clark  
Township Frank  
or  
Village  
or  
City Farmington (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 1132

File No. 18097-1

Primary Registration District No. 5286

Registered No. 2

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

FULL NAME Effie Margaret Collins

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Apr. 15</u> , 1917 (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. <u>27</u> ds. If LESS than 1 day, _____ hrs. or _____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		
NAME OF FATHER <u>Clarence Collins</u>	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Acosta, Mo.</u>	
MAIDEN NAME OF MOTHER <u>Edna Collins</u>	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Anson, Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
May 12, 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 15, 1917, to May 12, 1917, that I last saw him alive on May 12, 1917, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Marasmus

(Duration) 0 yrs. 0 mos. 27 ds.

Contributory

(SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) G. A. Coffin M. D.  
May 12, 1917 (Address) Farmington, Ia.

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

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

PLACE OF BURIAL OR REMOVAL Acosta Cemetery DATE OF BURIAL May 14, 1917

UNDERTAKER Phil Ware Farmington, Ia. ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Informant) Clarence Collins  
(ADDRESS) Farmington, Ia.  
Filed Oct. 10, 1917 Sadie Gray REGISTRAR

**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 "*Aslhemia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Con-genital*," "*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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH  
 County Clark  
 Township man  
 or  
 Village  
 or  
 City (NO. St. Ward)

Registration District No. 1137 File No.  
 Primary Registration District No. 5286 Registered No. 2

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

2 FULL NAME

Effie Margret Coffey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE  MARRIED  WIDOWED  OR DIVORCED  (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)

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH May 12 1917  
 (Month) (Day) (Year)

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

The CAUSE OF DEATH\* was as follows:  
Acute Gastritis

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)

Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) L. A. Coffey M. D.

191 (Address) 103

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (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.

15 Filed Jan 21 1918 Sadie Gray Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL ADDRESS

20 UNDERTAKER Phil & Wm. Washington

Original file, date Oct. 10 1917

All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

6-27

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

1809-1

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