

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

PLACE OF DEATH

County Andrain
Township Salt River
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 110 File No. 21234
Primary Registration District No. 5034B Registered No. 2

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

FULL NAME Mrs. Lougan Blum

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)

DATE OF DEATH June 23, 1917
(Month) (Day) (Year)

DATE OF BIRTH June 21, 1846
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 21, 1917, to June 23, 1917, that I last saw her alive on June 23, 1917, and that death occurred, on the date stated above, at 3¹⁸ m. THE CAUSE OF DEATH* was as follows:

AGE 71 yrs. 3 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

Pneumonia

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

107A (Duration) ___ yrs. ___ mos. ___ ds.

BIRTHPLACE (City or town, State or foreign country) Santa Fe Mo

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER John Bybee

(Signed) J. J. Flyant M. D. June 23, 1917 (Address) Molino Mo

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

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

MAIDEN NAME OF MOTHER Janetta Creed

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) Mrs Bert C. Berrey

Former or usual residence _____

(ADDRESS) Thompson Mo

PLACE OF BURIAL OR REMOVAL Midway Cemetery DATE OF BURIAL June 25, 1917

Filed June 23, 1917 J. J. Flyant REGISTRAR

UNDERTAKER McPheeters Bros ADDRESS Mexico Mo

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St.: _____ Ward) _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE _____ MARRIED _____ WIDOWED _____ OR DIVORCED _____
(Write the word)

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

AGE _____
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)

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

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

(ADDRESS) _____

Filed _____, 191____, _____
 REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____, (Month) _____, (Day) _____, (Year) _____

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. The CAUSE OF DEATH* was as follows:

Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds.
(SECONDARY)
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____, 191____ (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.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____
 UNDERTAKER _____ ADDRESS _____

1 PLACE OF DEATH

County Andrain
Township Salt River
or
Village
or
City

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

CERTIFICATE OF DEATH

Registration District No. 110 File No.
Primary Registration District No. 5034B Registered No. 2
(NO. St. Ward)

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

2 FULL NAME Louisa Blum

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE widow
MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH
(Month) (Day) (Year)
7 AGE
yrs. mos. ds. 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)

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 June 23 1917
Filed 23 1917 J. J. Blum
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 23 1917
(Month) (Day) (Year)

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:
pneumonia
AI Bronchitis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
(Address) 191

*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 McPheters Bros. 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*, *Compositor*, *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);

21234

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 "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 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.)