

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

1 PLACE OF DEATH

Polk

County

Township

or

Village

or

Bolivar, Mo.

City

(NO.)

Registration District No. 701
Primary Registration District No. 4422

File No. 26179

Registered No. 49

St. Ward

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

2 FULL NAME Lucy A. Dwyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX female 4 COLOR OR RACE white 5 SINGLE widowed
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

16 DATE OF DEATH
July 14, 1917
(Month) (Day) (Year)

6 DATE OF BIRTH
Nov. 19th, 1833
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
July 8, 1917, to July 14, 1917
that I last saw h. OP alive on July 14, 1917
and that death occurred, on the date stated above, at 11.53 P.M.

7 AGE
83 yrs. 7 mos. 25 ds.
If LESS than
1 day.....hrs.
or.....min.?

The CAUSE OF DEATH* was as follows:
Cerebral haemorrhage.

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

8.2 hrs
162 (Duration)..... yrs. mos. 1 hour. ds.

9 BIRTHPLACE
(City or town, State or foreign country) State of Ohio

CONTRIBUTORY
(Secondary)

10 NAME OF FATHER Richard Compton
State of Va.

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

12 MAIDEN NAME OF MOTHER Dorcis Odor
State of Va.

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

(Signed) W. J. Roberts M. D.
July 18, 1917. (Address) Bolivar, Missouri.

*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
(Informant) Mrs. J. Roberts
(Address) Bolivar Mo

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 July 16, 1917 J. F. Roberts
Registrar

19 PLACE OF BURIAL OR REMOVAL Greenwood Cemtery DATE OF BURIAL 7/19/17, 1917

20 UNDERTAKER Clifford Winslow ADDRESS Bolivar, Mo.

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.

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 "Asthma," "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

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

1 PLACE OF DEATH
County Polk

Township

Registration District No. 901

File No.

Village

Primary Registration District No. 4422

Registered No. 49

City Bolivar

(NO.)

St.

Ward)

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

2 FULL NAME Luey, A. Sawyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX ♀

4 COLOR OR RACE W

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) W

16 DATE OF DEATH July 14 7

(Month)

(Day)

(Year)

6 DATE OF BIRTH

(Month)

(Day)

1 (Year)

7 AGE

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

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.

CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY Smoking

(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) W. S. ... M. D.

9-8, 1917 (Address) Bolivar, Mo.

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(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
of death..... yrs..... mos..... ds. 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

ADDRESS

Clifford ...

Satisfactory Information Supplied. **TEMPORARILY SUPPLIED.**
Satisfactory Information Supplied.

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 Sept 9

1917

Registrar J. G. Roberts

Original file, date....., 19.....

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

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26179
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 inter-current) 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.)