

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.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	Barry	Registration District No.	35
Township	Pleasant Ridge	File No.	30943
or Village		Primary Registration District No.	5043
or City		Registered No.	
FULL NAME		St.	Ward
Lora Lawson		[If death occurred in a hospital or institution, give its NAME instead of street and number]	

PERSONAL AND STATISTICAL PARTICULARS		
SEX Female	COLOR OR RACE White	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
DATE OF BIRTH May 22 - 1900 (Month) (Day) (Year)		
AGE 17 yrs. 5 mos. 21 ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work House work at home. (b) General nature of industry, business, or establishment in which employed (or employer) 870		
BIRTHPLACE (City or town, State or foreign country) Barry Co. Missouri.		
PARENTS	NAME OF FATHER J. W. Lawson	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) Barry Co. Missouri.	
	MAIDEN NAME OF MOTHER Minnie Bolton	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) Barry Co. Missouri.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Minnie Bolton (ADDRESS) Verona, Mo. R. # 3.		
Filed Sep 13, 1917 J. T. Black REGISTRAR		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH September 13, 1917 (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from Sept. 9, 1917, to Sept 13, 1917, that I last saw her alive on Sept 13/1917, 1917, and that death occurred, on the date stated above, at 2:40 p.m. The CAUSE OF DEATH* was as follows: Meningitis. (Not Epidemic)	
61 (Duration) ___ yrs. ___ mos. 3 ds.	
Contributory Chronic Otitis Media. (SECONDARY) (Duration) 15 yrs. ___ mos. ___ ds.	
(Signed) W. S. Loveland M. D. Sept 13, 1917 (Address) Verona Mo	
*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 Usual residence	
PLACE OF BURIAL OR REMOVAL Clayhill Mo	DATE OF BURIAL Sept 14, 1917
UNDERTAKER C. J. Manley	ADDRESS Verona 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*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, 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 surgi al 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.)