

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

PLACE OF DEATH

County Cook
Township Clear Creek
or Clear Creek
Village Clear Creek
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 223
Primary Registration District No. 5304

File No. 31399
Registered No. 18

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

FULL NAME Laura Jane Mayfield

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (write the word)

DATE OF BIRTH Sept 13 1917
(Month) (Day) (Year)

AGE 67 yrs. 10 mos. 13 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Virginia

PARENTS
NAME OF FATHER Thomas Dicklider
BIRTHPLACE OF FATHER (City or town, State or foreign country) Va
MAIDEN NAME OF MOTHER Marg J Melvin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Anna Belle Mayfield
(ADDRESS) Pleasant Green Mo

Filed Sept 17 1917 J S Parrish
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 13 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 11 1917, to Sept 13 1917, that I last saw her alive on Sept 13 1917, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion
118C

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Stomach disease
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J S Parrish M. D.
Sept 13 1917 (Address) Osceola Green

*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 New Lebanon DATE OF BURIAL Sept 16 1917
UNDERTAKER Spillers ADDRESS Otterville

PLACE OF DEATH

County.....

Township.....

or.....

Village.....

or.....

City.....

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO. St. Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	(Month), 191..... (Year)
	DATE OF BIRTH		

AGE yrs. mos. 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)

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 (Month), 191..... (Day), 191..... (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 (SECONDARY) (Duration) yrs. mos. ds.
 (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
UNDERTAKER	ADDRESS

FILE OF DEATH
 County Crocker REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW
 Township C. Green Registration District No. 223 File No.
 Village Primary Registration District No. 5304 Registered No. 13
 City (NO St. Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Laura Jane Mayfried

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) 1 (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)

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

5 Filed Sept. 17 1917 J. S. Parish Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 13 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: Acute Indigestion
 (Duration) yrs. mos. 2 ds.

CONTRIBUTORY Heart, valve (Secondary) (Duration) 10 yrs. mos. ds. (Signed) Sept 13 1917 (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

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]

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), *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 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.)

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