

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

1 PLACE OF DEATH

County Ripley
Township Harris
or
Village Wagon
or
City (NO. St. Ward)

Registration District No. 1058 File No. 9/26 32938
Primary Registration District No. 5991 Registered No.

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

2 FULL NAME Birdie Swan

PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH 9 26 1917
(Month) (Day) (Year)

6 DATE OF BIRTH 10 17 1900
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 9/24, 1917, to 9/26, 1917, that I last saw her alive on 9/25, 1917, and that death occurred, on the date stated above, at 230 a.m.

7 AGE 17 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

THE CAUSE OF DEATH* was as follows
Confusion & chill
(Duration) yrs. mos. ds.

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

9 BIRTHPLACE (City or town, State or foreign country) MO

PARENTS 10 NAME OF FATHER Sam Farmer
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) MO
12 MAIDEN NAME OF MOTHER Sarah Welkerson
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) MO

(Signed) M. B. Waddle M. D. 9/26, 1917 (Address) Success

*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) Rohel Swan
(Address) Alain

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 9/26, 1917 W. W. Slagle Registrar

19 PLACE OF BURIAL OR REMOVAL Burbar MO DATE OF BURIAL 9/27, 1917 removal
20 UNDERTAKER P. Spaulder 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*, *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); *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 "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.)

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

CERTIFICATE OF DEATH

County Ripley Registration District No. File No.
 or Harris Primary Registration District No. Registered No.
 Township
 or
 Village
 or
 City (NO. St. Ward) [If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number.]

2 FULL NAME

Berdie Swan

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>F</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u>	16 DATE OF DEATH	<u>Sept 28</u> 191 <u>7</u> (Month) (Day) (Year)
6 DATE OF BIRTH			17 I HEREBY CERTIFY, that I attended deceased from	
(Month) (Day) (Year)			191..... to..... 191.....	
7 AGE			that I last saw him..... alive on..... 191.....	
If LESS than 1 day..... hrs. or..... min.?			and that death occurred, on the date stated above, at..... m.	
8 OCCUPATION (a) Trade, profession, or particular kind of work..... (b) General nature of industry business, or establishment in which employed (or employer).....			The CAUSE OF DEATH* was as follows: <u>Congestion Chills</u> <u>Pernicious Malaria</u>	
9 BIRTHPLACE (City or town, State or foreign country)			(Duration)..... yrs..... mos..... ds.	
PARENTS	10 NAME OF FATHER		CONTRIBUTORY (Secondary) <u>04</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)		(Duration)..... yrs..... mos..... ds.	
	12 MAIDEN NAME OF MOTHER		(Signed) <u>M. B. Beadell</u> M. D.	
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)		<u>9/27</u> , 191 <u>8</u> (Address) <u>Success ave</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
(Address)			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)	
15			At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.	
Filed <u>9/27</u> , 191 <u>7</u> <u>F. W. W. Slagle</u> Registrar			Where was disease contracted if not at place of death?	
			Former or usual residence.....	
			19 PLACE OF BURIAL OR REMOVAL <u>Roubidour Mo</u> DATE OF BURIAL <u>9/28</u> 191 <u>7</u>	
			20 UNDERTAKER <u>M. H. Hish</u> ADDRESS <u>Naylor</u>	

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

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

Revised United States Standard Certificate of Death

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

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83438

BUREAU OF VITAL STATISTICS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 DIVISION OF VITAL STATISTICS
 OFFICE OF STATISTICS
 WASHINGTON, D. C. 20001

STATE OF _____
 COUNTY OF _____
 CITY OF _____

NAME OF DECEASED: _____
 SEX: _____
 AGE: _____
 OCCUPATION: _____
 CAUSE OF DEATH: _____
 DATE OF BIRTH: _____
 ADDRESS: _____
 1911