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.

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

1 PLACE OF DEATH

County Henry

Township McNeven or Village Leesville or City (NO. St.; Ward)

Registration District No. 350

Primary Registration District No. 5490

File No. 34920

Registered No. 110

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

2 FULL NAME Elizabeth A Huffard

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Female	16 DATE OF DEATH: Oct 16th, 1917 (Month) (Day) (Year)
4 COLOR OR RACE: White	17 I HEREBY CERTIFY, that I attended deceased from Oct 15th, 1917, to Oct 16th, 1917, that I last saw her alive on Oct 16th, 1917, and that death occurred, on the date stated above, at 10 a.m.
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married	The CAUSE OF DEATH* was as follows: Hemorrhage Brain 82A (Duration) yrs. mos. 1 ds.
6 DATE OF BIRTH: Aug 21, 1845 (Month) (Day) (Year)	CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
7 AGE: 73 yrs. mos. ds. If LESS than 1 day, hrs. or min.?	(Signed) J. J. Stephens M. D. Oct 16, 1917 (Address) Leesville Mo.
8 OCCUPATION (a) Trade, profession, or particular kind of work: House work (b) General nature of industry business, or establishment in which employed (or employer)	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
9 BIRTHPLACE (City or town, State or foreign country): Ohio	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.
PARENTS 10 NAME OF FATHER: Solomon Bridestine	Where was disease contracted if not at place of death?
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Penn.	Former or usual residence: Leesville Mo
12 MAIDEN NAME OF MOTHER: Don't know	19 PLACE OF BURIAL OR REMOVAL: Tebo Cemetery. DATE OF BURIAL: Oct 17, 1917
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio	20 UNDERTAKER: J. E. Consolus. ADDRESS: Clinton Mo
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) F J Huffard (Address) Leesville Mo.	
15 Filed Oct 17, 1917 B. B. Barr Registrar	

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, 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), *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 *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.)

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 Henry

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

Registration District No. 350 File No. .....

Primary Registration District No. 5490 Registered No. 110

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

2 FULL NAME Elzykar Hubbard

PERSONAL AND STATISTICAL PARTICULARS

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 //

Filed ....., 191..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 16 ..... (Month) ..... (Day) ....., 191 7 ..... (Year)

17 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:

Hemorrhage of Brain

.....

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) ..... M. D.

....., 191..... (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 .....

SUPPLEMENTARY Satisfactory Information Supplied

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]

34920

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