

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

35546

PLACE OF DEATH  
County Boone  
Township Salt Run  
or Novelty, Mo  
Village Novelty, Mo  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 446 File No. \_\_\_\_\_  
Primary Registration District No. 5066 Registered No. \_\_\_\_\_

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

FULL NAME Laverda Hunter

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED x WIDOWED OR DIVORCED Wid  
(Write the word)

DATE OF BIRTH Mo 29, 1917  
(Month) (Day) (Year)

AGE 70 yrs. 6 mos. 19 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Adams Co Ill

NAME OF FATHER Carroll Hill

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

MAIDEN NAME OF MOTHER Laverda James

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Adams Co Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Carl Hunter

(ADDRESS) Novelty Mo

Filed Oct 19, 1917 M E Hill REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 17, 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 1, 1917, to Oct 17, 1917, that I last saw her alive on Oct 17, 1917, and that death occurred, on the date stated above, at 3.0 m.

The CAUSE OF DEATH\* was as follows:  
Paralysis  
81A  
82A

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 17 ds.

Contributory (SECONDARY) Blood clot  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 17 ds.

(Signed) L. Hill M. D.  
10/18, 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.

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 Novelty, Mo DATE OF BURIAL 10, 19, 1917

UNDERTAKER J. W. Hudson ADDRESS Novelty, Mo

**PLACE OF DEATH**

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

County \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_)  
 Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

(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 OR MARRIED OR WIDOWED OR DIVORCED (If *rife*, the word)  
 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
 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 \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) 191\_\_\_\_  
 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 \_\_\_\_\_ in \_\_\_\_\_.  
 The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Duration) \_\_\_\_\_  
 (Signed) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Duration) \_\_\_\_\_  
 \_\_\_\_\_ M. D. \_\_\_\_\_  
 \_\_\_\_\_ (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ 191\_\_\_\_  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

HTLA County  
Township  
or  
Village  
or  
City

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

Registration District No. 446  
Primary Registration District No. 5066  
File No.  
Registered No.  
St. Ward

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

2 FULL NAME *Lambda Hunter*

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *Mar. 29 1847*  
(Month) (Day) (Year)

7 AGE *70*  
If LESS than 1 day... hrs. or... min.?  
*6 mos. 19 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)

9 BIRTHPLACE  
(City or town, State or foreign country) *Adams Co Ill*

10 NAME OF FATHER *Don't know*

11 BIRTHPLACE OF FATHER  
(City or town, State or foreign country) *Don't know*

12 MAIDEN NAME OF MOTHER *Edginda James*

13 BIRTHPLACE OF MOTHER  
(City or town, State or foreign country) *Adams Co Ill*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Learl Hunter son*  
(Address) *Novelty MO*

15 Filed *Oct 19 1917*  
*7 M & Hill*  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 17 1917*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *1917* to *1917*, that I last saw him *alive on* *1917*, and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH\* was as follows:  
*Paralysis*  
*Acute ascending*  
*Paralysis*  
*Acute ascending*  
(Duration) *17* yrs. *17* mos. *17* ds.

CONTRIBUTORS (Secondary)  
*Don't know*  
(Duration) *17* yrs. *17* mos. *17* ds.  
(Signed) *L. Hill* M. D.  
*Nov 17 1917* (Address) *Novelty MO*

\*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: *Novelty MO*

19 PLACE OF BURIAL OR REMOVAL *Novelty MO* DATE OF BURIAL *10 19 1917*

20 UNDERTAKER *Jno W Hudson* ADDRESS *Novelty MO*

Original file, date *Oct 19 1917*

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]

35526

**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*; *Broncho-pneumonia* ("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 inter-current) 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.)