

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

41885

PLACE OF DEATH
County Lafayette
Township Middleton
or
Village _____
or
City Waverly (NO. _____ St. _____ Ward _____)

Registration District No. 465 File No. _____
Primary Registration District No. 4278 Registered No. 21

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

FULL NAME Mrs Kate Rice

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Negro SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
AGE 21 yrs. 11 mos. 16 ds. If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Waverly Mo

PARENTS
NAME OF FATHER Henry Porter
BIRTHPLACE OF FATHER (City or town, State or foreign country) Waverly Mo
MAIDEN NAME OF MOTHER Luella Swancy
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Waverly Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ale Baker
(ADDRESS) Waverly Mo

Filed Dec 22 1917 G. B. Melvin REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 31, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 16, 1917, to Dec 31, 1917, that I last saw her alive on Dec 20, 1917, and that death occurred, on the date stated above, at 11:30 pm.

The CAUSE OF DEATH* was as follows:
Inanition following structural of
Esophagus
1163 A
116 A (Duration) 8 yrs. 5 mos. 5 ds.

Contributory Taking concentrated Lye
(SECONDARY) suicidal intent
(Duration) 8 yrs. 5 mos. 5 ds.
(Signed) Geok Helling M. D.
12-23, 1917 (Address) Waverly 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 _____

PLACE OF BURIAL OR REMOVAL Waverly Mo DATE OF BURIAL Dec 23, 1917
UNDERTAKER J. R. Landrum ADDRESS Waverly

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered 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 (Use this 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

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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____, 191 (Day) _____ (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:

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

Contributory
(SECONDARY)

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

(Signed)

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. 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

DATE OF BURIAL

UNDERTAKER

ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

1) PLACE OF DEATH
County Lafayette
Township Wardsly
City Wardsly (NO. 465 Registration District No. 4278 File No. 4278 Registered No. 4278)
St. Wardsly Ward Wardsly (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Kate Rice

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Jan 6 1896
(Month) (Day) (Year)

7 AGE 21 yrs 11 mos 15 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)

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)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 21 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 1917
The CAUSE OF DEATH* was as follows:
Insanitation
(Duration) yrs. mos. ds.

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

(Signed) W. B. Landrum M. D.
(Address) Wardsly, 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

19 PLACE OF BURIAL OR REMOVAL Wardsly Mo. DATE OF BURIAL 1917
20 UNDERTAKER W. B. Landrum ADDRESS Wardsly

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Landrum
(Address) Wardsly, Mo.
Filed Dec 22 1917 W. B. Landrum Registrar

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]

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), 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.)

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