

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

1 PLACE OF DEATH
County Dearborn
Township ~~Dearborn~~ Registration District No. 81 File No. 12158
or DeKalb Prop Primary Registration District No. 4049 Registered No. 3
City..... (NO..... St..... Ward)

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

2 FULL NAME Margrett Jane West

PERSONAL AND STATISTICAL PARTICULARS 3 MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OF RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
6 DATE OF BIRTH April 30 1844
(Month) (Day) (Year)
7 AGE 73 yrs. 11 mos. 5 ds. If LESS than 1 day..... hrs. or..... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work House wife 1266
(b) General nature of industry business, or establishment in which employed (or employer) 1945
132A

16 DATE OF DEATH Apr 5 1918
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from April 3 1918 to April 4 1918, that I last saw her alive on April 4 1918, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:
Injury from broken limb, -
fracture of neck of Femur, -
accidental,
(Duration) 1 yrs. — mos. 1 1/2 ds.

9 BIRTHPLACE (City or town, State or foreign country) DeKalb Mo
10 NAME OF FATHER Daniel Chitwood
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ca
12 MAIDEN NAME OF MOTHER Nancy Taylor
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

CONTRIBUTORY (Secondary) —
(Duration) — yrs. — mos. — ds.
(Signed) E. B. McAdow M. D.
April 5, 1918. (Address) DeKalb 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.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Beula West
(Address) DeKalb Mo

19 PLACE OF BURIAL OR REMOVAL DeKalb County DATE OF BURIAL April 1 1918
20 UNDERTAKER Preston Byrum ADDRESS DeKalb Mo

15 Filed April 6, 1918. Wm. W. Shelton
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 septicæmia," "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

1 PLACE OF DEATH
Buckman
County
Township
or
Village
or
City

Registration District No. *81* File No.
Primary Registration District No. *4049* Registered No. *3*
St. Ward

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

2 FULL NAME *Margaret Jane West*

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
Satisfactory information supplied.

7 AGE If LESS than 1 day... hrs. or... min? Satisfactory information supplied.

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (for employer) Satisfactory information supplied.

9 BIRTHPLACE (City or town, State or foreign country) Satisfactory information supplied.

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) Satisfactory information supplied.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address) Satisfactory information supplied.

15 Filed *Aug 11^a* 1918. *Ms. W. J. Shelton* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Apr 5 1918*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Satisfactory information supplied.* 191 to 191 that I last saw h. *alive* 191 and that death occurred, on the date stated above, at *17th St.* m.

The CAUSE OF DEATH* was as follows:
Injury from broken limb - fracture of neck of femur - lacerated due to falling from door step.
(Duration) *3 1/2* yrs. mos. ds.

CONTRIBUTORY *Nephritis* (Secondary) (Duration) yrs. mos. ds. (Signed) *E. B. McAdams* M. D. *Aug 9^a* 1918 (Address) *Dekalb Ga.*

*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) *Satisfactory information supplied.* 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 *Satisfactory information supplied.* DATE OF BURIAL 191

20 UNDERTAKER ADDRESS

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12158
"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 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 "*Asihenia*," "*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.)