

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

1 PLACE OF DEATH

County

*Depphin*  
*Saline*

Township

or

Village

or

City

(NO)

St.

Ward)

Registration District No.

*290*

File No.

12731

Primary Registration District No.

*5408*

Registered No.

*440*

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

2 FULL NAME

*(Not Known)*

*Lindsey*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH *Nov 7 1909*  
(Month) (Day) (Year)

7 AGE *8 yrs 5 mos 27 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) *Sumner Co Mo.*

PARENTS  
10 NAME OF FATHER *Henderson Lindsey*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Depphin Co Mo.*  
12 MAIDEN NAME OF MOTHER *Mans*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Texas*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Wally Chouhler* (Address) *Sumner Mo*

15 Filed *5-1* 191*8* *P. M. Daniel* Registrar

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *4 21 1918*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 191..... to ..... 191..... that I last saw him..... alive on ..... 191..... and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows:  
*Hydrocephaloid Brain*  
*150 157A*  
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) *from Birth* (Duration)..... yrs..... mos..... ds. (Signed) *W. S. Hughes* M. D. (Address) *Sumner 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 *Wide Cemetery* DATE OF BURIAL *Apr. 22 1918* ADDRESS *Sumner Mo*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. ATTENDERS should be stated EXACTLY. PHYSICIANS should state EXACTLY. ATTENDERS should be stated EXACTLY.

# 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 freman*, 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) Colton 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 "Asthena," "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 child-birth 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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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County *Madison*  
Township *Saline*  
or  
Village  
or  
City

Registration District No. *290*  
Primary Registration District No. *5408*

File No.  
Registered No. *440*

(NO. .... St. .... Ward)

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

FULL NAME *Priscilla Lindsey*

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE ..... 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 *Josephine Mays*  
13 BIRTHPLACE OF MOTHER  
(City or town, State or foreign country)

14 THE ABOVE I HAVE TO THE BEST OF MY KNOWLEDGE  
(Informant) .....  
(Address) .....

15  
Filed *3-3* 191*8* *9 4 15 10 AM*  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*4-21*, 191*8*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 191....., to ..... 191....., that I last saw him ..... 191....., and that death occurred, on the date stated above, at ..... m. The CAUSE OF DEATH\* was as follows:

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

CONTRIBUTORY (Secondary) ..... (Duration) ..... mos. .... ds.  
(Signed) ..... M. D.  
..... 191..... (Address) .....

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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 .....

Satisfactory Information Supplied

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