

PLACE OF DEATH

County Marries
 Township Miller
 or
 Village
 or
 City (NO. St. Ward)

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

13928

Registration District No. 1040
 Primary Registration District No. 627C

File No.
 Registered No. 8

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

FULL NAME Mary Elizabeth Mulay

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Widow WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH unknown, 1840
 (Month) (Day) (Year)

AGE about 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work House-wife
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Tennessee

NAME OF FATHER James M. Lawson

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

MAIDEN NAME OF MOTHER Susan Knox

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Lawson

(ADDRESS) Brays, Mo

Filed Apr 15 1918 B.W. Winkelmann
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 14, 1918
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to April 16, 1918,
 that I last saw her alive on _____, 191____,
 and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:
Died suddenly without
medical attendance (death due
to Paralysis of heart.)
20 + 11 (Duration) yrs. mos. 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.

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 Lawson Cemetery DATE OF BURIAL April 16, 1918

UNDERTAKER x ROE Lawson ADDRESS Brays, Mo

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, peritoneum*, 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County James MillerTownship James Miller

or

Village James Miller

or

City James Miller (NORegistration District No. 1040File No. 6376Primary Registration District No. 8Registered No. 8St. James Miller Ward 8

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

2 FULL NAME

Mary Elizabeth Walen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX F 4 COLOR OR RACE W 5 SINGLE W
MARRIED
WIDOWED
OR DIVORCED
(Write the word)16 DATE OF DEATH Apr 14, 1918
(Month) (Day) (Year)6 DATE OF BIRTH 1 (Month) 1 (Day) 1 (Year)17 I HEREBY CERTIFY, that I attended deceased from 1918 to 1918,
that I last saw him alive on 1918,
and that death occurred, on the date stated above, at 1918 m.7 AGE 1 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:

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)

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

(Signed) Richard Lawson
Sept 3, 1918 (Address) Bray P.O. 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)

(Address)

15 Filed Sept 5 1918 E. M. Winkelman Registrar19 PLACE OF BURIAL OR REMOVAL Lawson Cemetery DATE OF BURIAL Sept 3, 191820 UNDERTAKER V. A. Lawson ADDRESS

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association.]

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