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

20750

PLACE OF DEATH

1. County Macon Co
Township Charlton
or
Village Ardmore
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 529 File No. _____
Primary Registration District No. 5705 Registered No. 68

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

FULL NAME Mollie Ronse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
COLOR OR RACE: Negro
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

5A. DATE OF BIRTH: Not Known (Month) (Day) 1868 (Year)

6. DATE AGE
7. AGE: 50 yrs. ____ mos. ____ ds.
If LESS than 1 day, ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Cook & Housekeep
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country): Va

9. PARENTS
NAME OF FATHER: Dont No
BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont No
MAIDEN NAME OF MOTHER: Dont No
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont No

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nach Ronse
(ADDRESS) Ardmore Mo

Filed June 13, 1918. W J Harned REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 6 (Month) 11 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from May 26, 1918, to June 1, 1918, that I last saw her alive on June 1, 1918, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Ptomain Poison
1775
(Duration) ____ yrs. ____ mos. 6 ds.

Contributory (SECONDARY) _____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W J Harned M. D.
June 13, 1918 (Address) Ardmore

*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: Ardmore Hills
DATE OF BURIAL: 6/12 1918
UNDERTAKER: Albert Kinnies
ADDRESS: Macon Mo

PLACE OF DEATH

County .....

Township .....
or
Village .....
or
City ..... (NO. ....., ... St.: ..... Ward)

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

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 MARRIED WIDOWED OR DIVORCED (*Write* 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)

PARENTS

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) ..... 191.... (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 .....

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

Contributory
(SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

Revised United States Standard

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite);

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

OF DEATH Macon Registration District No. 529 File No. 20750

Chastern Primary Registration District No. 5705 Registered No.

(No. , St. Ward)

NAME Mollie Rouse

Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
n	B.	m.

MARRIED, WIDOWED, OR DIVORCED
USBAND OF
WIFE OF

E OF BIRTH (MONTH, DAY AND YEAR)

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

IPATION OF DECEASED
Trade, profession, or
cular kind of work
General nature of industry,
oess, or establishment in
h employed (or employer)
Name of employer

IPLACE (CITY OR TOWN)
TE OR COUNTRY)

AME OF FATHER

HPLACE OF FATHER (CITY OR TOWN)
TATE OR COUNTRY)

DEN NAME OF MOTHER

PLACE OF MOTHER (CITY OR TOWN)
E OR COUNTRY)

AI

June 13, 19 W. J. Harned
REGISTR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JUN 11 1950

17.
I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , and that death occured, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ptomain Poison
Resulting from eating
spoilt Sardines
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 164
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. J. Harned, M. D.
, 19 (Address) Ardmore

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

LL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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 *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.