

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

1 PLACE OF DEATH
County Green
Township Taylor
Village Springfield
City Springfield (NO. Route 1 Stafford St., Ward)

Registration District No. 5438 File No. 33001
Primary Registration District No. 844 Registered No. 22

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

2 FULL NAME Mary Alice Melton

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Oct 7 1895
(Month) (Day) (Year)

7 AGE 23 yrs. mos. ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) "

9 BIRTHPLACE (City or town, State or foreign country) Mo.

PARENTS 10 NAME OF FATHER Mrs. Bodenheimer
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
12 MAIDEN NAME OF MOTHER Lizzie Fielder
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Chas. F. Melton
(Address) Route 1 Stafford

15 Filed Nov 4 1918 J. Foster Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 22 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 19th 1918, to Oct 21, 1918, that I last saw her alive on Oct 20th 1918, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Plasma poisoning
auto-toxemia
6 55
(Duration) 8 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary) 8
(Duration) yrs. mos. ds.
(Signed) W. E. F. Brown M. D.
10/22 1918 (Address) Youngfield 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 Danforth Cem. DATE OF BURIAL Oct 23, 1918

20 UNDERTAKER Lohmeyer and Co. ADDRESS 305 N. Walnut

1 PLACE OF DEATH

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

County
 Township Registration District No. File No.
 or Village Primary Registration District No. Registered No.
 or City (NO.) St.: Ward)
 If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
 4 COLOR OR RACE
 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
 6 DATE OF BIRTH: (Month) 1 (Day) 1 (Year)
 7 AGE yrs. mos. ds. If LESS than 1 day: hrs. or min.?

8 OCCUPATION (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)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)
 (Address)
 15 Filed 191 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) 191. (Year)
 17 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:

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

*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 DATE OF BURIAL 191
 20 UNDERTAKER ADDRESS

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

1. PLACE OF DEATH

County Franklin Registration District No. 944 File No. _____
 Township Lebanon Primary Registration District No. 5438 Registered No. 22
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hr. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14. INFORMANT Chas F Melton
 (Address)

15. FILED 11-4, 1918 Jessie J Foster REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 22 1918

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute leukemia
 (duration) _____ yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) St. Leo
 (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) J. M. J. Brown, M. D., 19____ (Address) Springfield, Mo.

*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

Danbuth, Mo. 10-24 1918

20. UNDERTAKER ADDRESS

Lochner Springfield, Mo.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY. Springfield, Mo.

SUPPLEMENTARY

COPIES THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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, 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.

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