

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Dr Lee Coff.

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

1 PLACE OF DEATH

County: *Greene*

Township:

or Village:

or City: *Springfield*

Registration District No. *378*

Primary Registration District No. *2007*

File No. *39202*

Registered No. *858*

(NO. *719 Belmont* St.; Ward)

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

2 FULL NAME *June Adkins*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *Nov 23* 191*8*
(Month) (Day) (Year)

6 DATE OF BIRTH *Nov 9* 191*8*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Nov 19* 191*8*, to *Nov 23* 191*8*, that I last saw *her* alive on *Nov 23* 191*8*, and that death occurred, on the date stated above, at *5 P* m.

7 AGE yrs. mos. *14* 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 *Child* (b) General nature of industry business, or establishment in which employed (or employer) *Child*

153
Dysentery
(Duration) yrs. mos. ds.

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

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

10 NAME OF FATHER *Halter Adkins*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Mo.*

12 MAIDEN NAME OF MOTHER *Lavinia Buren*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Mo.*

(Signed) *Dr Lee Coff* M. D. *1124* 191*8* (Address) *SPRINGFIELD Mo*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Halter Adkins*

(Address) *719 Belmont*

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.....

15 NOV 24 1918 Filed

19 PLACE OF BURIAL OR REMOVAL *Hazelwood* DATE OF BURIAL *Nov 24* 191*8*

20 UNDERTAKER *Shawyer & Co* ADDRESS *305 N. Walnut*

Edwin F. James Registrar
Jessie B. Johnson Deputy Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT WRITE IN THESE SPACES

1 PLACE OF DEATH

County

Township

or

Village

or

City

STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

City

St.

Ward)

File No.

Registered No.

(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

(a) Trade, profession, or business or establishment in which employed (or employer)

(b) General nature of industry

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, 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from, 191..... to, 191..... (Month) (Day) (Year)

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:

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

CONTRIBUTORY (Secondary)

(Signed)..... (Duration)..... yrs. mos. da.

....., 191..... (Address)..... M. D.

*Sets 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. da.

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 Greene

Registration District No. 315

File No. _____

Township _____

Primary Registration District No. 2001

Registered No. 858

City Springfield (No. _____)

St. _____

Ward _____

2. FULL NAME Jane Atkins

(a) Residence No. _____

(Usual place of abode)

St. _____

Ward _____

(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 _____

4. COLOR OR RACE _____

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (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 _____

(Address)

JAN 29 1919

Edwin F. James
REGISTRAR
Dorothy B. Johnson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 23 1918

17.

I HEREBY CERTIFY, That I attended deceased from Nov. 1918 to Nov. 23, 1918 that I last saw him alive on Nov. 22, 1918, and that death occurred on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Core 21 pneumonia (infection)
of body

(duration) 18 yrs. _____ mos. 6 ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Hospital

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

JAN 28 1919
JAN 28 1919
Lu box, M. D.
(Address) 426 Lander St

*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

ALL INFORMATION ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL 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

39202

"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.