

PLACE OF DEATH

County: Oregon

41209 a ✓

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHTownship: WoodsideRegistration District No. 636File No. 41209-aVillage: isPrimary Registration District No. 5843Registered No. 3

City: _____ (NO. _____ St.: _____ Ward)

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

FULL NAME: Sallie Hall

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female COLOR OR RACE: White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): MarriedDATE OF BIRTH: June 24, 1900
(Month) (Day) (Year)AGE: 18 yrs. 4 mos. 23 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: Oregon U MO
City or town, State or foreign countryNAME OF FATHER: Henry DixonBIRTHPLACE OF FATHER: unknown
(City or town, State or foreign country)MAIDEN NAME OF MOTHER: Saisy BarrettBIRTHPLACE OF MOTHER: MO
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant: Ben Hall
(ADDRESS) Alton MO Post #3Filed 1/23 1919 Emuel Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: November 17, 1918
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Nov 15, 1918, to Nov 17, 1918, that I last saw her alive on Nov 17, 1918, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

PneumoniaContributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) W. D. Dungan M.D. M. D.
11/21/1918 (Address) Greer MO

*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: Hickory grove DATE OF BURIAL: Nov 19, 1918
UNDERTAKER: Ewert Hall ADDRESS: Greer MO

PLACE OF DEATH

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

County.....
 Township.....
 or
 Village.....
 or
 City..... (NO.....
 Registration District No.....
 Primary Registration District No.....

File No.

Registered No.

St.: Ward)

(If death occurred
 hospital or infirmary
 give its NAME in
 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)....., 19..... (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)

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..... 19..... REGISTRAR.....

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 19....., 19.....
 (Month)..... (Day)..... (Year).....

I HEREBY CERTIFY, that I attended deceased
 that I last saw h..... alive on....., 19....., to....., 19.....
 and that death occurred, on the date stated above, at.....
 The CAUSE OF DEATH* was as follows:

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

Contributory
 (SECONDARY)

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

..... 19..... (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, &c.)
 RECENT RESIDENTS

At place
 of death..... yrs..... mos..... ds..... 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

19.....

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

PLACE OF DEATH

County Oregon Registration District No. 636 File No. _____
 Township Woodsdale Primary Registration District No. 5843 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

FULL NAME

Dollie Hall

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

SEX _____ 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m.

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

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

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs or _____ min.

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 _____

7. 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)

INFORMANT (Address) _____

FILED 1/23 19 19 Ernest Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 17 19 18

17. I HEREBY CERTIFY That I attended deceased from Nov 17 1918 to Nov 18 1918 that I last saw her alive on Nov 17 1918, and that death occurred on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia and influenza

CONTRIBUTORY (SECONDARY) _____ (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. C. Hennigan M. D. 19 (Address) Green Ave.

*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

20. UNDERTAKER

ADDRESS

Mount Hall Green Ave.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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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