

1. PLACE OF DEATH.

County

Township

Inc. Town

City

Registration District No.

Primary Registration District No.

(No.

St.;

Ward)

File No.

STATE OF ARKANSAS

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

4670

30

2 FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6. DATE OF BIRTH July 13, 1888
Month Day Year

7. AGE 35 yrs. 7 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ minf

8. OCCUPATION (a) Trade, profession, or particular kind of work House Wife (b) General nature of industry, business, or establishment in which employed (or employer) 10

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER Ralph Faulkner

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Rachel Faulkner

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Robertson(Address) Europea Springs Ark15. Filed Feb 15 1919 M. N. Roberts

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2/14, 1919
Month Day Year

17. I HEREBY CERTIFY That I attended the deceased from 2/5, 1919, to 2/13, 1919, that I last saw her alive on 2/13, 1919, and that death occurred on the date stated above, at ___ m.

The CAUSE OF DEATH * was as follows:

Influenza

10

Duration ___ yrs. ___ mos. ___ ds.

Contributory SECONDARY PneumoniaDuration ___ yrs. ___ mos. 9 ds.Signed J. R. Reynolds, M. D.2/15, 1919 Address Memphis Ark

*State the DISEASE CAUSING DEATH, or, in death 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

BURIAL

19. PLACE OF BURIAL OR REMOVAL Lat Mo Yummy DATE OF REMOVAL 191920. UNDERTAKER ✓ADDRESS ✓

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 of 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 DEATH state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL 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 statements 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 Barry Registration District No. 38 File No.
 Township White River Primary Registration District No. 5037 Registered No.
 City (No) St. Ward)

2. FULL NAME

Ollie Robertson

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1919

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

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

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) M. D. , 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Rochester Feb 15 1919

20. UNDERTAKER ADDRESS

T. J. McKing Central Ave

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important. Be properly classified.

SUPPLEMENTARY

14. INFORMANT (Address) FILED Feb 15 1919 M. H. Roberts REGISTRAR

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

4707

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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.