

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

**1. PLACE OF DEATH**

County Clatsop  
Township Leiston  
City Leiston (No.       )

Registration District No. 537  
Primary Registration District No. 6099

File No. 8269  
Registered No. 133  
St.        Ward       

**2. FULL NAME**

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

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 26 1887

7. AGE 31 YEARS MONTHS 8 DAY 23 IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer):  
(c) Name of employer

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

10. NAME OF FATHER W. R. Bullockson  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Martha Gibson  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.  
(STATE OR COUNTRY)

14. INFORMANT John Patterson  
(Address) Bloomfield Mo.

15. FILED 2/18 1919 S. D. Davis  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1919

17. I HEREBY CERTIFY, That I attended deceased from 2/18 1918 to 7/18 1919 that I last saw her alive on 7/18 1919 and that death occurred, on the date stated above, at 8 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
cardiac asthma  
Following attack of acute  
asthma patient had influenza  
1 month ago. (duration) 11 yrs. 4 mos. 4 da.  
CONTRIBUTORY (SECONDARY) NO (duration)        yrs.        mos.        da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH:       

DID AN OPERATION PRECEDE DEATH:        DATE OF       

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) S. D. Davis, M. D.  
, 19        (Address)

\*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 Washley Cemetery DATE OF BURIAL Feb. 19 1919

20. UNDERTAKER W. A. Harper ADDRESS Bloomfield

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

# 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 pneumonia* ("Pneumonia," unqualified, *Tuberculosis of lungs, meningis, pericarcinoma, Sarcoma*, etc., of ..... origin; "Cancer" is less definite; avoid use for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic nephritis*, etc. The contributory (secondary) affection need not be stated if not important. Example: *Measles* (disease causing death); *Bronchopneumonia* (secondary). Never report mere symptoms or terminations such as "Asthenia," "Anemia" (merely "Anemia"), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Secondary"), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Shock," "Uremia," "Weakness," etc. If a definite disease can be ascertained, state it. Always qualify all diseases resulting from birth or miscarriage, as "PUERPERAL" "PUERPERAL peritonitis," etc. State the nature of the operation which surgical operation was under which VIOLENT DEATHS state MEANS OF INJURY as ACCIDENTAL, SUICIDAL, OR HOMICIDE, if probably such, if impossible to determine. Examples: *Accidental drowning; Railway accident; Revolver wound; Railway accident; Poisoned by carbolic acid—peritonitis*. The nature of the injury, as fracture, and the consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (See also instructions on statement of cause of death.) (Approved by the Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above terms and refuse to accept certificates of death. Thus the form in use in New York City state will be returned for additional information with the following diseases, without explanation, if not stated: *Abortion, cellulitis, childbirth, hemorrhage, gangrene, gastritis, erysipelas, meningitis, necrosis, peritonitis, phlebitis, pyemia, septicemia*. But general adoption of the minimum list suggests vast improvement, and its scope can be extended.

ADDITIONAL SPACE FOR FURTHER STATEMENT BY PHYSICIAN.