

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

1 PLACE OF DEATH

County Sullivan Registration District No. 929 File No. 12760
Township Pleasant Hill Primary Registration District No. 6122 Registered No. 11
or
Village St. Ward)
City (NO. St. Ward)

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

2 FULL NAME

Nora Murphy

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH May 14 1893
(Month) (Day) (Year)

7 AGE 25 yrs. 10 mos. 13 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS
10 NAME OF FATHER James Brinsley
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Sullivan Co Mo
12 MAIDEN NAME OF MOTHER Julia Wood
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sullivan Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dee Jones
(Address) Milan Mo

15 Filed 4/12 1919 J.H. Rogan Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 27 1919
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 3/25 1919 to Nov 27 1919

that I last saw h..... alive on..... 1919 and that death occurred, on the date stated above, at 6122 m.

The CAUSE OF DEATH* was as follows:
Diphtheria
1498
11A
109A

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

(Signed) [Signature] M. D.
3/27 1919 (Address) Milan 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 W.P. Spriggs Co Mo DATE OF BURIAL Nov 27 1919

20 UNDERTAKER C. Schaeue ADDRESS Milan Mo

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, peritonaeum*, 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," "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 child-birth or miscarriage, as "PUERPERAL septicaemia," "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.)

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County Sullivan Registration District No. 929 File No. _____
 Township Pleasant Hill Primary Registration District No. 6122 Registered No. 11
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Nora Murphy
 (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

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

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

DATE OF BIRTH (MONTH, DAY AND YEAR)

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) _____

INFORMANT (Address) _____

FILED 3/20 1923

J. M. Rogers
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-27 1919

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:

Influenza

CONTRIBUTORY (SECONDARY) Pneumonia (duration) yrs. mos. ds. 5
Cystitis (duration) yrs. mos. ds. 4

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) Spitzer M.D.
 _____ 19____ (Address) Mulvaney

*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 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.]

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"Typhoid pneumo-
pneumonia ("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 inter-
current) affection need not be stated unless im-
portant. Example: Measles (disease causing death),
29 ds.; Bronchopneumonia (secondary), 10 ds.
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such as "Asthenia," "Anemia" (merely symptom-
atic), "Atrophy," "Collapse," "Coma," "Convul-
sions," "Debility" ("Congenital," "Senile," etc.),
"Dropsy," "Exhaustion," "Heart failure," "Hem-
orrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uremia," "Weakness," etc., when a
definite disease can be ascertained as the cause.
Always qualify all diseases resulting from child-
birth 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 rail-
way 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 undesir-
able 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, hemor-
rhage, 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.