

1 PLACE OF DEATH

County Cape Girardeau
 Township Cape Girardeau
 or
 Village
 or
 City Cape Girardeau (NO. St. Francis Hospital)

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 13289
 File No. 340

Registration District No. 126
 Primary Registration District No. 3009
 Registered No. 3

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

2 FULL NAME Ora Bell Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
 4 COLOR OR RACE White
 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
 6 DATE OF BIRTH Oct 15 1893
 (Month) (Day) (Year)
 7 AGE 25 yrs 5 mos 9 ds.
 If LESS than 1 day, hrs. or min.?
 8 OCCUPATION (a) Trade, profession, or particular kind of work. House Keeper
 (b) General nature of industry business, or establishment in which employed (or employer)

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

PARENTS
 10 NAME OF FATHER W F Myers
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Bollinger Co. Mo
 12 MAIDEN NAME OF MOTHER Linda Cooper
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bollinger Co. Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. F. Myers
 (Address) Galva, Mo

15 Filed 4/10 1919
Dr. J. B. Schell
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 9 1919
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 6th, 1919, to April 9th, 1919, that I last saw her alive on April 9th, 1919, and that death occurred, on the date stated above, at 11:42 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
12/19
 (Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) E. B. Schell M. D.
Apr 10, 1919. (Address) Cape Girardeau

*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. 9 ds. In the State yrs. mos. ds.
 Where was disease contracted if not at place of death? Galva, Mo
 Former or usual residence ←

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Union Hill Cemetery April 10, 1919

20 UNDERTAKER ADDRESS
Yorkers Lumber Co Cape Gir, Mo

LOCAL REGISTRATION RECORDS - 20 NOV 1911

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

1 PLACE OF DEATH

County

Township Registration District No. File No.

Village Primary Registration District No. Registered No.

City (NO) St. (Ward)

[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)	(Day)
7 AGE yrs. mos. ds.	(Year)

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

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 Filled 191..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month), 191..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191....., to 191....., 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..... ds.

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

(Signed) (Address) M. D.

*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) In the place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

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 Cape Girardeau Registration District No. 125 File No.
 Township Primary Registration District No. 3009 Registered No. 340
 City Cape Girardeau (No.) St. Ward)

2. FULL NAME

Gra Bell Myers
 (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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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, hrs. 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)

15. FILED 7/10, 1919 G. B. Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-9 1919

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis
117
 (duration) yrs. mos. ds.

CONTRIBUTORY Ruptured appendix (SECONDARY)
 (duration) yrs. mos. 3 ds.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF April 4/19

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? operation findings
 (Signed) G. B. Schultz M. D.

July 28, 1919 (Address) Cape Girardeau, Mo

*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

SUPPLEMENTARY

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

13289
"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 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 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.