

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

1 PLACE OF DEATH

County Macou
 Township Hudson or Village
 City (NO. St.; Ward)

Registration District No. 5133 File No. 20121
 Primary Registration District No. 5713 Registered No. 34

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

2 FULL NAME

Eliza Baker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed
 (Write the word)

6 DATE OF BIRTH Aug 21 1940
 (Month) (Day) (Year)

AGE 78 yrs. 10 mos. 15 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) Ind

10 NAME OF FATHER Gas Ingles

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind

12 MAIDEN NAME OF MOTHER Shelton

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6/16 1919
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 1 1919 to June 5 1919, that I last saw him alive on June 5 1919, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:
Guinea Worm

(Duration) I don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) Same as above
 (Duration) yrs. mos. ds.

(Signed) A. M. R... M. D.
June 1 1919 (Address) Macon, 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

4 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) May Baker
 (Address) Macon Mo & FN

19 PLACE OF BURIAL OR REMOVAL Fairview DATE OF BURIAL 6/17 1919

5 Filed 6-10 1919 W. H. Miller Registrar

20 UNDERTAKER Albert Sherris ADDRESS Macon, Mo.

1 PLACE OF DEATH

County
 Township
 or Village
 or City (NO.)

Registration District No. File No.
 Primary Registration District No. Registered No.
 St. Ward)

If death occurred in hospital or institution give its NAME inside of street and number.

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 5 SINGLE
 4 COLOR OR RACE MARRIED
 OR DIVORCED
 (WRITE IN WORD)

6 DATE OF BIRTH 1 (Year)
 (Month) (Day)
 If LESS than 1 day hrs. or min.?

7 AGE yrs. mos. ds.

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 Filed 191 Registrar

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) 191 (Year)

17 I HEREBY CERTIFY, that I attended deceased free 191
 that I last saw h alive on 191
 and that death occurred, on the date stated above, at 191
 The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)
 (Signed) (Duration) yrs. mos.
 (Address) (Duration) yrs. mos. M.

*State the Disease Causing Death, or, in death from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transfer or Recent Residents)
 At place of death yrs. mos. ds. In the State yrs. mos.
 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 Macon Registration District No. 533 File No. _____
 Township Hudson Primary Registration District No. 5713 Registered No. 34
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

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

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 housewife
 (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 6-10, 1919 W. Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-6-1919

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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) _____, 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 _____ 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.]

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

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"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 gives 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.