

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

1. PLACE OF DEATH

County New Madrid Registration District No. 53 File No. 22905-a
 Township Anderson Primary Registration District No. 4033 Registered No. 5
 City Hidom (No. _____) St. _____ Ward _____

2. FULL NAME Ruth Marie Cobb

(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. 4 mos. _____ da. _____
 How long in U.S., if of foreign birth? yrs. _____ mos. _____ da. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
 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.
1 6 16 _____
 8. OCCUPATION OF DECEASED infant
 (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) Granite City, Illinois
 (STATE OR COUNTRY)

10. NAME OF FATHER Lee Cobb.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Georges
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Emma Hurst

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

14. INFORMANT Lee Cobb. (Father)
 (Address) Hidom Mo.

15. FILED 7/28 1919 M.V. Munson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 26th 1919
 17. I HEREBY CERTIFY That I attended deceased from July 10th 1919 to July 26th 1919
 that I last saw h. alive on July 23, 1919, and that death occurred, on the date stated above, at 9 o'clock P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Enterocolitis

104 (duration) yrs. _____ mos. 20 da. _____

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. _____ mos. _____ da. _____

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical symptoms
 (Signed) J. H. Cooper M. D.
7/28 1919 (Address) Hidom, 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 Staubel DATE OF BURIAL 7-27 1919

20. UNDERTAKER J. H. Cooper ADDRESS Hidom Mo

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County.....
 Township.....
 City..... (No. St. Ward)

Registration District No.
 Primary Registration District No.
 Registered No.

File No.
 Registered No.
 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.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (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 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs.
 (duration) yrs.

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

DID AN OPERATION PRECEDE DEATH..... DATE OF

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

20. UNDERTAKER
 DATE OF BURIAL
 ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County New Maduk Registration District No. 55 File No.
Township Gideon Primary Registration District No. 4033 Registered No. 5
City (No.) St. Ward)

2. FULL NAME Ruth Marie Cook
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
76. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/10/1918
77. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 6 16

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 26 1919
17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw live on 19....., and that death occurred on the date stated above, at m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
(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)

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

14. INFORMANT (Address)
15. FILED 7/28/19 M.V. Munnick REGISTRAR
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

THIS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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 *Lantern*, *Physician*, *Compositor*, *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. 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 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.