

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

1 PLACE OF DEATH

County Macon  
Township Hudson  
or  
Village  
or  
City Macon (NO. \_\_\_\_\_ St. 2 Ward)

Registration District No. 533 File No. 44 28048  
Primary Registration District No. 3097 Registered No. \_\_\_\_\_

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

2 FULL NAME Alice Lynn Thompson

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 Mar 6 1849  
(Month) (Day) (Year)  
7 AGE 70 yrs 6 mos 3 ds. If LESS than 1 day, hrs. or min.?

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) Va

PARENTS  
10 NAME OF FATHER Cabinn Petcher  
11 BIRTHPLACE OF FATHER Mo  
(City or town, State or foreign country)  
12 MAIDEN NAME OF MOTHER Virginia Brown  
13 BIRTHPLACE OF MOTHER Va  
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Peray Lynn  
(Address) Macon Mo

15 Filed 10-10 1919 A. H. Miller  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 13 1919, to Sept 15 1919, that I last saw her alive on Sept 15 1919, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:  
Acute Myocarditis  
MI  
(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos 2 ds.

CONTRIBUTORY (Secondary) Coroner of Medicine  
(Duration) 2 yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.  
(Signed) A. H. Miller M. D.  
Sept 17 1919 (Address) Macon Mo

\*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)  
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 Bloomington Cemetery DATE OF BURIAL Sept 17 1919  
20 UNDERTAKER Albert Skinner ADDRESS Macon Mo

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....  
Township ..... Registration District No. .... File No. ....  
or .....  
Village ..... Primary Registration District No. .... Registered No. ....  
or .....  
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) ..... 191..... (Year)	
7 AGE	..... yrs. .... mos. .... ds. .... If LESS than 1 day.....hrs. or.....min.?	
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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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..... The CAUSE OF DEATH\* was as follows:

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

(Signed) ..... yrs. .... mos. .... ds. .... (Duration) ..... (Address) ..... M. D.

\*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

DATE OF BURIAL ..... 191.....

20 UNDERTAKER

ADDRESS

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

-6-

**1. PLACE OF DEATH**

County Macon Registration District No. 033 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3027 Registered No. 44  
 City Macon (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Alice Taylor Thompson  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-15-1919

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

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.

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife (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) \_\_\_\_\_

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)

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) \_\_\_\_\_

\*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.)

14. INFORMANT (Address) \_\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

15. FILED 10-10-1919 W. H. Melick REGISTRAR

20. UNDERTAKER ADDRESS Alice

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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*, *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. 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*, *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 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.

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