

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

1. PLACE OF DEATH

County Linn Registration District No. 497 File No. 30690
 Township _____ Primary Registration District No. 4907 Registered No. 13
 City Browning (No. _____) St. _____ Ward _____

2. FULL NAME

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 11 _____

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) Ohio

10. NAME OF FATHER

Sam'l Moore

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) don't know

12. MAIDEN NAME OF MOTHER

Lucinda Bryant

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) don't know

14. INFORMANT Mrs Stella Thompson
 (Address) Chelletoha

15. FILED 10-28-19 Mrs. A. G. Bergman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/24/19 19

17. I HEREBY CERTIFY, That I attended deceased from Mich. 20, 1919, to 10/24/19, 19, that I last saw h. alive on 10/24/19, 19, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS

Chronic Interstitial
131 Nephritis
9 1/2 yrs (duration) several years yrs. mos. ds.
 CONTRIBUTOR Insufficiency of Heart
 (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Laclede Mo

DID AN OPERATION PRECEDE DEATH. no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. M. Bunsie, M. D.

10/24/19 (Address) Laclede 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 Oakwood Cem Milan Mo DATE OF BURIAL Oct 26 19 19

20. UNDERTAKER O. 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*, *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) *Sales-ocery*; (a) *Foreman*, (b) *Automobile fac-*
 material worked on may form part of the
 ament. Never return "Laborer," "Fore-
 anager," "Dealer," etc., without more
 cification, as *Day laborer*, *Farm laborer*,
coal mine, etc. Women at home, who are
 the duties of the household only (not paid
 s who receive a definite salary), may be
Housewife, *Housework* or *At home*, and
 Church, 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 occu-
 pation at beginning of illness. If retired from busi-
 ness, that fact may be indicated thus: *Farmer (re-*
tired, 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*; *Broncho-*
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 in-
 tercurrent) affection need not be stated unless im-
 portant. Example: *Measles* (disease causing death),
29 ds.; *Bronchopneumonia* (secondary), *10 ds.*
 Never report mere symptoms or terminal conditions,
 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.

D. FOR BINDING
 NK—THIS IS A PER
 AGE should be stated E
 classified. Exact state

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