

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state exactly.

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

PLACE OF DEATH
County Morgan
Township Marian
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 574 File No. 6-8077
Primary Registration District No. 5792-a Registered No. 577

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

FULL NAME Eelna Orwan

PERSONAL AND STATISTICAL PARTICULARS	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	
DATE OF BIRTH <u>Feb. 2, 1872</u> (Month) (Day) (Year)	
AGE <u>47</u> yrs. <u>11</u> mos. <u>14</u> ds. If LESS than 1 day, ____ hrs. or ____ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Maid</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>General Household</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Morgan Co Mo</u>	
PARENTS	NAME OF FATHER <u>George W Orwan</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Penn</u>
	MAIDEN NAME OF MOTHER <u>Margrett Sanders</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Morgan Co Mo</u>

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Feb 7, 1920</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Sept 20, 1919</u> , to <u>Feb 7, 1920</u> , that I last saw her alive on <u>Feb 7, 1920</u> , and that death occurred, on the date stated above, at <u>3:30</u> am.	
The CAUSE OF DEATH* was as follows: <u>Carcinoma</u> <u>50</u> <u>47 B</u> ✓	
(Duration) <u>2</u> yrs. ____ mos. ____ ds.	
Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.	
(Signed) <u>W. J. Wheat</u> M. D. -191- (Address) <u>Barnett mo</u>	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
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 _____	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Orwan
(ADDRESS) Barnett mo
Filed 2/8 1920 W P Hattler
REGISTRAR

PLACE OF BURIAL OR REMOVAL Haverwell DATE OF BURIAL Feb 8, 1920
UNDERTAKER N. A. Gaws ADDRESS Barnett 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*, *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 *Houskeepers* 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*, *Sar-*

coma, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "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.)



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

1. PLACE OF DEATH

County Morgan Registration District No. 597 File No. _____
 Township Marion Primary Registration District No. 5792a Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Edna Orwan

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 7, 1920

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

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____ that I last saw him _____ alive 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.

Carcinoma of mammary glands extended into lung yrs. mos. da.

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 _____

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

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) W. J. Wheat, M. D.
 , 19 (Address) Barnett mo

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 _____

15. FILED 2/8 1920 W. J. Hatler REGISTRAR

20. UNDERTAKER _____

ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY

CAUSE OF DEATH STATEMENT OF OCCUPATION IS VERY IMPORTANT. REGISTARS 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.]

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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 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 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.