

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Boone
Township Cedar
or
Village
or
City

Registration District No. 76 File No. 11581
Primary Registration District No. 5/10B Registered No. 7
City (NO. _____) St. _____ Ward _____

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

FULL NAME Fannie E. Westbrook

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---|--|
| SEX <u>Female</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED _____ WIDWED OR DIVORCED (If in the word) |
| DATE OF BIRTH <u>May 8, 1956</u> (Month) (Day) (Year) | | |
| AGE <u>63</u> yrs. <u>11</u> mos. <u>0</u> ds. | | If LESS than 1 day, _____ hrs. or _____ min.? |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housekeeping</u> | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Holls Summit Callaway Co. Mo</u> | | |
| PARENTS | NAME OF FATHER <u>Edwin W. Wallace</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u> | |
| | MAIDEN NAME OF MOTHER <u>Ruth Ann Hall</u> | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Holls Summit Callaway Co. Mo</u> | |

1 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 30, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1919, 191____, to March 31, 1920, that I last saw her alive on March 28, 1920, and that death occurred, on the date stated above, at 12:00 m.
The CAUSE OF DEATH was as follows:

Cancer, Sarcoma, of left Inguinal Region
(Duration) 2 yrs. _____ mos. _____ ds.

Contributory (SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.
Signed W. P. Meigs M. D.
3/27 1920 (Address) Hartsburg Mo

*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 _____

PLACE OF BURIAL OR REMOVAL Mount Pleasant Co. Mo DATE OF BURIAL 3/31 1920

UNDERTAKER Vanacourt, Ashland Mo
Sappington

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. G. Westbrook
(ADDRESS) Hartsburg Mo.

Filed Apr. 8 1920

REGISTRAR

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 a hospital or institution, give its NAME instead of street and number.)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
 COLOR OR RACE _____
 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (If not the word)

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

AGE _____ yrs. _____ mos. _____ ds.
 IF LESS than
 1 day _____ hrs.
 or _____ min.?

OCCUPATION _____
 (a) Trade, profession, or business, or establishment in which employed (or employer)
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE _____
 (City or town, State or foreign country)

NAME OF FATHER _____
 BIRTHPLACE OF FATHER _____
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____
 BIRTHPLACE OF MOTHER _____
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____

Filed _____ 191____ REGISTRAR _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) 191____

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) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (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.
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) _____
 At place of death _____ yrs. _____ mos. _____ ds. In the _____
 Where was disease contracted _____ yrs. _____ mos. _____ ds.
 If not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____ ADDRESS _____

RECORD AFFIRMED
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. CAUSE OF DEATH, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1. PLACE OF DEATH

County Boone
Township Cedar
City (No. _____) _____

Registration District No. 76
Primary Registration District No. 5110 B

File No. _____
Registered No. _____

2. FULL NAME

Fannie E. Westbrook

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

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 _____
(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 Apr 9 1920 Clarence R. Bledsoe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 30 1920

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 _____ m.

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.

BY A MARSHAL PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR THIS SERVICE.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

18511

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 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.