

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

16968

1 PLACE OF DEATH
County Livingston
Township Monroe
or
Village
or
City

Registration District No. 514 File No. 30
Primary Registration District No. 5683 Registered No. 3
St. Ward

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

2 FULL NAME Sylvia Rosalie Damrell

| PERSONAL AND STATISTICAL PARTICULARS | | | | MEDICAL CERTIFICATE OF DEATH | |
|---|---|---|--|--|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word) | | 16 DATE OF DEATH <u>April 11, 1920</u> (Month) (Day) (Year) | |
| 6 DATE OF BIRTH <u>Dec 26, 1919</u> (Month) (Day) (Year) | | | | 17 I HEREBY CERTIFY, that I attended deceased from <u>April 6, 1920, to April 11, 1920</u> , that I last saw her alive on <u>April 11, 1920</u> , and that death occurred, on the date stated above, at <u>3:45</u> m. | |
| 7 AGE <u>3 yrs. 16 mos. 16 ds.</u> | | If LESS than 1 day, hrs. or min.? | | The CAUSE OF DEATH* was as follows: <u>1077 Nephritis (acute)</u> <u>135</u> | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry business, or establishment in which employed (or employer) | | | | Duration <u>11</u> yrs. <u>3</u> mos. <u>3</u> ds. | |
| 9 BIRTHPLACE (City or town, State or foreign country) <u>Ludlow, Mo</u> | | | | CONTRIBUTORY (Secondary) <u>Pneumonia</u> Duration <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. | |
| PARENTS | 10 NAME OF FATHER <u>Lee Damrell</u> | | | (Signed) <u>Geo More</u> M. D. | |
| | 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ludlow Mo</u> | | | <u>April 13, 1920</u> (Address) <u>Ludlow Mo</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>Eunice Proctor</u> | | | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal. | |
| 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Braymo Mo</u> | | | | 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death, yrs. mos. ds. In the State, yrs. mos. ds. | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lee Damrell</u> (Address) <u>Ludlow, Mo</u> | | | | Where was disease contracted if not at place of death? Former or usual residence | |
| 15 Filed <u>5/13, 1920</u> <u>Geo More</u> Registrar | | | | 19 PLACE OF BURIAL OR REMOVAL <u>Monroe Cem.</u> | |
| | | | | DATE OF BURIAL <u>5/12, 1920</u> | |
| | | | | 20 UNDERTAKER <u>O Busby</u> | |
| | | | | ADDRESS <u>Ludlow Mo</u> | |

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 *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, peritonaeum*, 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," "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 septicaemia," "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 Livingston Registration District No. 574 File No. 30
Township Monroe Primary Registration District No. 5683 Registered No. 3
City (No. _____) _____ St. _____ Ward _____

2. FULL NAME

Sylvia Rosalie Dairvahl
(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) 2

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26 1919

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
3 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(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 Leo Dairvahl

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

12. MAIDEN NAME OF MOTHER Emmie Proctor

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

14. INFORMANT Lee Day (Address) Ludlow Mo

15. FILED 4/13 1920 Geo Morse REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-11 19 20

17. I HEREBY CERTIFY, That I attended deceased from 4/6 1920, to 4/11 1920, that I last saw him alive on 4/11 1920, and that death occurred on the date stated above, at 4/11 3 9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nephritis Acute

CONTRIBUTORY (SECONDARY) Chronic Bronch. (duration) yrs. mos. ds. 15

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS None
(Signed) Geo Morse M. D.

19 (Address) Ludlow 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 Mount Cem. DATE OF BURIAL 4/12 1920

20. UNDERTAKER A Dierby ADDRESS Ludlow

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

897691

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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 sug^d need will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.