

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

1. PLACE OF DEATH

County New Madrid
Towship Como
City Como

Registration District No. 605
Primary Registration District No. 5804

File No. 17107
Registered No. _____
St. _____ Ward)

2. FULL NAME

Nancy Page
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1846-7-15

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 9 ✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeping
(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) Illinois

10. NAME OF FATHER Joseph Adcock

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

12. MAIDEN NAME OF MOTHER Doesn't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Arthur Johnson
(Address) Malden Mo

15. FILED 4/15/20 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 13 - 1920

17. I HEREBY CERTIFY That I attended deceased from April 14, 1920, to April 15, 1920 the last saw alive on April 14, 1920 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

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

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) D. Blackman
(Address) Como 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 Como Mo DATE OF BURIAL April 16 1920

20. UNDERTAKER Thomas C Knight ADDRESS Como Mo

N. B.—Every item of information should be accurately 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.

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 helpfulness 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 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 give 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.

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

1. **PLACE OF DEATH**
 County New Madrid Registration District No. 605 File No. _____
 Township Como Primary Registration District No. 5804 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. **FULL NAME** Nancy Page
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
<u>73</u>	<u>9</u>	<u>1</u>	

8. **OCCUPATION OF DECEASED**
 (a) Trade, profession, or particular kind of work House Wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. **BIRTHPLACE (CITY OR TOWN)** see
 (STATE OR COUNTRY) _____

10. **NAME OF FATHER** Joseph Alcock

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

12. **MAIDEN NAME OF MOTHER** do not know

13. **BIRTHPLACE OF MOTHER** (CITY OR TOWN) _____
 (STATE OR COUNTRY) not known

14. **INFORMANT** Arthur Johnson
 (Address) Malden Mo.

15. **FILED** 4/15/20 J. E. Goddington
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH (MONTH, DAY AND YEAR)** 4-15-20

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to 4/15/20 19____ that I last saw _____ live on 4/14/20, 19____, and that death occurred on the date stated above, at 10:09 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) by none
 (duration) yrs. mos. ds. _____

18. **WHERE WAS DISEASE CONTRACTED**
 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) C. B. Blackmon M. D.
4/15/20 (Address) Parma 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** Como. MO. DATE OF BURIAL 4/16/20 19____

20. **UNDERTAKER** J. C. Wright ADDRESS Parma Mo.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

17107

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