

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

1 PLACE OF DEATH

County Perry
Township Pine Grove Registration District No. 1128 File No. 27573-A
Village _____ Primary Registration District No. 5879A Registered No. _____
City _____ (NO. _____ St. _____ Ward _____)

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

2 FULL NAME Philomine Hayden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
6 DATE OF BIRTH April 29, 1834
(Month) (Day) (Year)
7 AGE 86 yrs. 5 mos. 7 ds.
IF LESS than 1 day, hrs. or min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) General house work

9 BIRTHPLACE
(City or town, State or foreign country) Perry Co. Mo

PARENTS
10 NAME OF FATHER John Marawille
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) France
12 MAIDEN NAME OF MOTHER Leont Brown
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Leont Brown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Victor Brewer
(Address) Clasgarville Mo.

15 Filed Aug. 31, 1920 J. H. Westman
By Elias Shachens Sub Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 29, 1920
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from Aug. 7, 1920 to Aug. 28, 1920
that I last saw her alive on Aug. 28, 1920
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
131 162 Heurily
(Duration) yrs. 1 mos. ds.

CONTRIBUTORY Old age
(Secondary)
(Duration) yrs. mos. ds.
(Signed) John A. Brown M. D.
Sept. 2, 1920 (Address) Bellevue, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18 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.

19 PLACE OF BURIAL OR REMOVAL Bellevue Mo DATE OF BURIAL Aug. 31, 1920

20 UNDERTAKER Phil Leuchel ADDRESS Perryville Mo

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

1 PLACE OF DEATH

County
 Township
 Village
 City
 Registration District No. File No.
 Primary Registration District No. Registered No.
 City (NO St. Ward)
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
 4 COLOR OR RACE
 5 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

6 DATE OF BIRTH (Month) 1 (Day) 1 (Year)

7 AGE yrs. mos. ds.
 If LESS than 1 day hrs.
 or min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry business, or establishment in which employed (or employer)

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH (Month) 191 (Year)

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.....m.

The CAUSE OF DEATH* was as follows:

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

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

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

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

13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
 (Signed) (Address) M. D., 191
 *State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted if not at place of death?
 Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....

20 UNDERTAKER ADDRESS 191.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)
 (Address)

15 Filed 191 Registrar

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH
 County Perry Registration District No. 1128 File No. _____
 Township Bois Brule Primary Registration District No. 5879a Registered No. 36
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Philomine Hayden
 (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

MEDICAL CERTIFICATE OF DEATH

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 Widowed

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 5 7

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) General Housework
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Perry, Mo. (STATE OR COUNTRY)

10. NAME OF FATHER John McManville

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

12. MAIDEN NAME OF MOTHER not known

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-29-20 1920

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1920 to Aug 29 1920
 that I last saw alive on Aug 28 1920, and that death occurred on the date stated above, at 3 P. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
nephritis chronic

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) John G. Brown M.D.
 19 (Address) Belgium Ind.

*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 Victor Brown
 (Address) Claryville Mo

15. FILED August 30 1920 Frank H. Obermann REGISTRAR
By Alois Stalens Exp

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Belgium Mo DATE OF BURIAL Aug 31st 1920

20. URBERTAKER Phil Lueckel ADDRESS Perryville Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Every item of information should be carefully supplied.

SUPPLEMENTARY

Revised United States Standard Certificate of Death:

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

27573-A

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, 8 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.