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

1. PLACE OF DEATH
County: Boone — Registration District No. 73 — File No. 28573
Township: Columbia — Primary Registration District No. 3074 — Registered No. 172
City: ..... No. ..... St. ..... Ward)

2. FULL NAME: Victoria Stevenson
(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: F
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: Wm Stevenson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 3-8-1875

7. AGE: Years 45 — Months 6 — Days 16 — If LESS than 1 day, ... hrs. or ..... min.

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): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN): Boone Co
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Jno. T. Buckner
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Missouri
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Nancy Wright
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Missouri
(STATE OR COUNTRY)

14. INFORMANT: Wm Stevenson
(Address): Columbia Mo

15. FILED: Jul 25, 1920 James Gordon, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept. 24 1920

17. I HEREBY CERTIFY, That I attended deceased from 7-15-20, 19..., to Sept-24-, 1920 that I last saw her alive on 9-23-, 1920, and that death occurred, on the date stated above, at 20 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
[illegible]
..... (duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (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? .....
(Signed) J. A. Taylor, M. D
9/25, 1920 Address Columbia 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: Columbia Mo — DATE OF BURIAL: 9-26 1920

20. UNDERTAKER: C. H. Van Leeuwen, Parker & Co — ADDRESS: Columbia 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*, *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; Bron pneumonia* ("Pneumonia," unqualified, is indefin *Tuberculosis of lungs, meninges, peritoneum,* *Carcinoma, Sarcoma*, etc., of . . . . . (name gin; "Cancer" is less definite; avoid use of "Tum for malignant neoplasms); *Measles; Whooping co Chronic valvular heart disease; Chronic interst nephritis*, etc. The contributory (secondary or tercurrent) affection need not be stated unless portant. Example: *Measles* (disease causing dea *29 ds.; Bronchopneumonia* (secondary), *10* Never report mere symptoms or terminal conditi such as "Asthenia," "Anemia" (merely sympt atic), "Atrophy," "Collapse," "Coma," "Con sions," "Debility" ("Congenital," "Senile," e "Dropsy," "Exhaustion," "Heart failure," "H orrhage," "Inanition," "Marasmus," "Old a "Shock," "Uremia," "Weakness," etc., whe definite disease can be ascertained as the ca Always qualify all diseases resulting from c birth or miscarriage, as "PUERPERAL *septicem* "PUERPERAL *peritonitis*," etc. State cause which surgical operation was undertaken. VIOLENT DEATHS state MEANS OF INJURY and qu as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or *probably* such, if impossible to determine defini Examples: *Accidental drowning; struck by way train—accident; Revolver wound of he homicide; Poisoned by carbolic acid—probably sui* The nature of the injury, as fracture of skull, consequences (e. g., *sepsis, tetanus*) may be st under the head of "Contributory." (Recomme tions on statement of cause of death approve Committee on Nomenclature of the Amer Medical Association.)

NOTE.—Individual offices may add to above list of und able terms and refuse to accept certificates containing t Thus the form in use in New York City states: "Certifi will be returned for additional information which give a the following diseases, without explanation, as the sole c of death: Abortion, cellulitis, childbirth, convulsions, he rhage, gangrene, gastritis, erysipelas, meningitis, miscarr necrosis, peritonitis, phlebitis, pyemia, septicemia, teta But general adoption of the minimum list suggested will vast improvement, and its scope can be extended at a date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.