

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 Clark

Township.....

or

Village.....

or

City Wyaconda

Registration District No. 194

File No. 31277-2

Primary Registration District No. 4117

Registered No. ....

(NO. .... St.; .... Ward)

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

2 FULL NAME Eunna Florence Perry

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH 10 2, 1920  
(Month) (Day) (Year)

6 DATE OF BIRTH January - 27, 1855  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from about Jan 1, 1919 to Sept 2, 1920, that I last saw her alive on Oct 2, 1920, and that death occurred, on the date stated above, at 3 P. M.

7 AGE 65 yrs. 8 mos. 5 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH\* was as follows:  
Tuberculosis  
3 1/2  
yr  
(Duration) 3 1/2 yrs. 0 mos. 0 ds.

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

9 BIRTHPLACE (City or town, State or foreign country) Shelby Co. Kentucky

PARENTS 10 NAME OF FATHER Vardaman Perry  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky  
12 MAIDEN NAME OF MOTHER Mary S. Hamon  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

(Signed) Wm. M. Carey M. D. Oct 4, 1920 (Address) Wyaconda Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) James Perry  
(Address) Gorin 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.....

15 Filed 19, 1920 Registrar

19 PLACE OF BURIAL OR REMOVAL Etna Cemetery DATE OF BURIAL Oct 4, 1920  
20 UNDERTAKER Guth & Porter ADDRESS Gorin 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, 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 "Asthemia," "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 child-birth 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.)

Dr. Mr. Reynolds says, "it ~~was~~ his opinion  
that Miss Perry had General T. B. He did not  
examine her lungs, but she had no cough."  
I have it that way, <sup>(General)</sup> on my records.

31277A

TO  
FROM



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

**1. PLACE OF DEATH**

County Clark Registration District No. 194 File No. \_\_\_\_\_  
 Township Wyaconda Primary Registration District No. \_\_\_\_\_ Registered No. 11  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

6. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

7. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan - 27 - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
65 | 8 | 5

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House Keeper  
 (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) James P. King  
Wyaconda Mo

Filed Nov 27, 1920 Mrs. Lizzie Doss REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 2 1920

17. I HEREBY CERTIFY That I certify deceased from \_\_\_\_\_ 19\_\_\_\_  
 to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw the \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_, and that  
 death occurred on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Subcutaneous  
Two or three yrs.

**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) W.C. McReynolds M. D.

Oct 4 1920 Address Wyaconda 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**

**DATE OF BURIAL**

Eluda Cemetery Oct 4 1920

**20. UNDERTAKER**

**ADDRESS**

Frank & Baskett Wyaconda Mo

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

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WRITE PERMANENTLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD

SUPPLEMENTARY

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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.