

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH
 County *St. Clair*
 Township *Washington*
 or
 Village
 or
 City

Registration District No. *1025 10* File No. *1 32354*
 Primary Registration District No. *604* Registered No. *9*
 (NO. St. Ward)

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

2 FULL NAME

Emilie Harrison

PERSONAL AND STATISTICAL PART

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

6 DATE OF BIRTH *Aug. 13, 1828*
 (Month) (Day) (Year)

7 AGE *92 yrs. 1. mos. 29. ds.*
 IF LESS than 1 day, hrs. or min.?

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

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

10 NAME OF FATHER *G. W. Bell*

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

12 MAIDEN NAME OF MOTHER *Paul Keulin*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *J. H. Harrison*
 (Address) *Ballins, Mo.*

15 Filed *Oct 18, 1920* *Hayes Burchett*
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 12, 1920*
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Oct. 5, 1920, to Oct. 12, 1920,*
 that I last saw her alive on *Oct. 5, 1920,*
 and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH* was as follows:

Septicaemia
1948
36 (Duration) yrs. mos. *10* ds.

CONTRIBUTORY *slight injury of foot*
 (Secondary) (Duration) yrs. mos. *15* ds.

(Signed) *C. L. Landaker* M. D.
Oct. 13, 1920 (Address) *Ballins, 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 *Preman, Mo.* DATE OF BURIAL *Oct. 13, 1920*

20 UNDERTAKER *none* ADDRESS *+*

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*; *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 St Clair Registration District No. 1025 File No. _____
 Township Washington Primary Registration District No. 6004 Registered No. 9
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Emiline Harrison
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-12 19 20

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw _____, live on _____, 19____, and that death occurred on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

Accidental injury to the foot
 (duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED

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

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

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH, no DATE OF _____

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

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS no

(Signed) L. F. Laudaker, M. D.

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

, 19 _____ (Address) Carrollton, Miss.

*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 _____ (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED _____ 19 _____ REGISTRAR

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAWS. CAUSE OF DEATH in plain terms, so that it may be properly translated. Exact State.

32354

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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.