

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

1. PLACE OF DEATH

County Butler Registration District No. 92 File No. 300
 Township Ellis Bluff Primary Registration District No. 5137 Registered No. _____
 City Fagus, Mo. (No. _____) St. _____ Ward _____

2. FULL NAME Clerey Thorn

(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 8 yrs. 2 mos. 5 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 19 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
48 3 5

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) Missouri
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Clay Co. Ark.
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Zacharias Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER Nancy C. Davis

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

14. INFORMANT Maurae Thorn
 (Address) Fagus Mo.

15. FILED 1/20 1921 W. A. Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 19, 1921

17. I HEREBY CERTIFY, That I attended deceased from Jan 18th 1920 to Jan 19th 1921
 that I last saw her alive on Jan 19th 1921, and that death occurred, on the date stated above, at 6:15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Tuberculosis (duration) 18 yrs. 1 mos. 5 ds.
 CONTRIBUTORY Heart (acute myocarditis) (SECONDARY) (duration) 0 yrs. 0 mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH... Fagus, Mo.

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination
 (Signed) Virgil E. Shale, M. D.
 , 19 (Address) Fagus, 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 Gravel Hill Ark. DATE OF BURIAL 1/20 1921

20. UNDERTAKER _____ 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 *Nons.*

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, peritonum, 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 give any of the following diseases, without explanation, as the sole cause of death: Abortion, callulitis, 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
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1. PLACE OF DEATH

County Butler Registration District No. 92 File No. _____
 Township _____ Primary Registration District No. 5137 Registered No. _____
 City _____ (No. _____) St. _____ Word _____

2. FULL NAME

Clacey Thorn

(a) Residence. No. _____ St. _____ Word _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED m
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 19 19 21

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw _____ alive on _____, 19____, and that death occurred on the date stated above, at _____ m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>48</u>	<u>3</u>	<u>8</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. da.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

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: _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS? _____

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

(Signed) _____, M. D.
 , 19 _____ (Address)

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14. INFORMANT (Address)

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

15. FILED 1/20 21 W. A. Bailey REGISTRAR

20. UNDERTAKER None ADDRESS _____

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.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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300