

My supplied. AGE should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County Pulaski  
Township Roubidoux  
Village  
City

Registration District No. 714 File No. 12896  
Primary Registration District No. 5944 Registered No. 8

2 FULL NAME Laura Belle Starnes (NO. St. Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
6 DATE OF BIRTH <u>Sept 8</u> 18 <u>92</u> (Month) (Day) (Year)		
7 AGE <u>28</u> yrs <u>7</u> mos <u>25</u> ds.	IF LESS than 1 day.....hrs. or.....min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>0</u>		
9 BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>		
PARENTS	10 NAME OF FATHER <u>Robert Wesley Logan</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	12 M maiden NAME OF MOTHER <u>Nancy Elizabeth Stewart</u>	
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky.</u>		

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3 1921  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 1 1921 to May 3 1921  
that I last saw her alive on May 3 1921  
and that death occurred, on the date stated above, at 12:52 m.

The CAUSE OF DEATH\* was as follows:  
Puerperal Septicemia  
following abortion  
36 (Duration)..... yrs..... mos..... 7 ds.

CONTRIBUTOR (Secondary) W. C. Mallett, M.D.  
(Signed) May 3, 1921 (Address) Bloomfield, 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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(formant) Jake Starnes  
(Address) Brownfield, Mo.  
11/5 1921 Edy Koonce  
Registrar

19 PLACE OF BURIAL OR REMOVAL Wicks Cemetery DATE OF BURIAL May 4 1921  
20 UNDERTAKER Pahner Undertaking Co ADDRESS Lebanon, Mo.

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

whatever, write *None*. For persons who have no 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 account of the disease causing death, state occupation of the disease causing death, state occupation of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* Care should be taken to report specifically children, not gainfully employed, as *At school* or *At home*, and entered as *Housewife, Housework* or *At home*, and *Housekeepers* who receive a definite salary, may be engaged in the duties of the household only (not paid *Laborer—Coal mine, etc.* Women at home, who are

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.)

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, cellulitis, chills, convulsions, hemorrhage, gastroenteritis, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work best improvement, and its scope can be extended at a later date.

Medical Association.) Committee on Nomenclature of the American Medical Association.) Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.) under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.) 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.) 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.) *homicide; Poisoned by carbolic acid—probably suicide; Railway train—accident; Revolver wound of head—homicide.* 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.*

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