

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 Shelby
Township Black Creek or Village or City (NO. 6092 St. Ward)
Registration District No. 831 File No. 19622
Primary Registration District No. 4504 Registered No. 9

2 FULL NAME Angie Stanley (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed
6 DATE OF BIRTH (Month) (Day) 1838 (Year)
7 AGE 83 yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry business, or establishment in which employed (or employer)
9 BIRTHPLACE (City or town, State or foreign country) Kingslee, Mo.
PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 13, 1921 (Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from July 4 to July 13, 1921, that I last saw her alive on July 12, 1921, and that death occurred, on the date stated above, at 11:50 a.m.
The CAUSE OF DEATH* was as follows:
myocarditis
CONTRIBUTORY Sues (Duration) 2 yrs. mos. ds.
(Signed) D. P. Mansfield M. D.
July 13, 1921 (Address) Shelbyville, Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John M. Wood (Address) Shelbyville, 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 3 yrs. 11 mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence Kingslee, Mo.

15 Filed July 13, 1921 Registrar W. C. Carson

19 PLACE OF BURIAL OR REMOVAL Mt. Pleasant, Ben. DATE OF BURIAL July 14, 1921
20 UNDERTAKER J. W. Thompson Son ADDRESS Shelbyville, Mo.

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MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County
 Township..... Registration District No. File No.
 or Village Primary Registration District No. Registered No.
 or City (NO.) St. Ward)
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 5 SINGLE 1 (Year)
 4 COLOR OR RACE MARRIED (Day) 191 (Year)
 WIDOWED
 OR DIVORCED (Write the word)

6 DATE OF BIRTH (Month) 1 (Day) 1 (Year)
 7 AGE yrs. mos. da.
 If LESS than 1 day hrs.
 or min. ?

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) 191 (Day) 191 (Year)
 17 I HEREBY CERTIFY, that I attended deceased from 191 to 191
 that I last saw h..... alive on 191
 and that death occurred, on the date stated above, at m.
 The CAUSE OF DEATH* was as follows:

9 BIRTHPLACE (City or town, State or foreign country)
 10 NAME OF FATHER (Duration) yrs. mos. da.
 11 BIRTHPLACE (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER (Duration) yrs. mos. da.
 13 BIRTHPLACE (City or town, State or foreign country)
 OF MOTHER
 CONTRIBUTORY (Signed)
 (Secondary) (Address) M. D.

*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. da. State yrs. mos. da.
 Where was disease contracted if not at place of death?
 Former or usual residence

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)
 (Address)
 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191
 20 UNDERTAKER ADDRESS

15 Filed 191 Registrar

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

1. PLACE OF DEATH

County Shelby Registration District No. 831 File No. _____
 Township Black Creek Primary Registration District No. 6092 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Angie Stanley
 (a) Residence No. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX f 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) w

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

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

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

8. OCCUPATION OF DECEASED Occupant
 (a) Trade, profession, or particular kind of work at University
 (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) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) _____

15. FILE NO. 002221 20-6000 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 19 21

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

*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

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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SUPPLEMENTARY

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*, *peritoneum*, 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 childbirth 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 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.