

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

1. PLACE OF DEATH

County Wendolph Registrar District No. 727 File No. 3918^a
 Township Cairo Primary Registration District No. 6963 Registered No. 3
 City X (No. X) St. X Ward X

2. FULL NAME

Mrs. Lillie Newton
 (a) Residence No. V St. X Ward. X (If nonresident give city or town and State)
 Length of residence in city or town where death occurred V yrs. X mos. X ds. How long in U.S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 11-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, X hrs. or X min.
44 6 29

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Horsekeeper
 (b) General nature of industry, business, or establishment in which employed (or employer) X
 (c) Name of employer X

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

10. NAME OF FATHER George Scott

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

12. MAIDEN NAME OF MOTHER Bettie Carter

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

14. INFORMANT James Newton (Address) near Cairo Mo.

15. By 10 1922 Dr. J. P. Allen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 9-1922

17. I HEREBY CERTIFY That I attended deceased from 19 1921 that I last saw him at home 1921 and that death occurred, on the date stated above, at 3:00 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
suicide - morphine
6 gr.
163H

(duration) X yrs. X mos. X ds.

CONTRIBUTORY (SECONDARY) X (duration) 1 yrs. X mos. X ds.

18. WHERE WAS DISEASE CONTRACTED 9/16 IF NOT AT PLACE OF DEATH? X

DID AN OPERATION PRECEDE DEATH? X DATE OF X

WAS THERE AN AUTOPSY? X

WHAT TEST CONFIRMED DIAGNOSIS? Micro
 (Signed) [Signature] (Address) Moberly 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 Antioch near Moberly DATE OF BURIAL 2/11 1922

20. UNDERTAKER Moberly ADDRESS Moberly Mo.

Revised United States Certificate of Death

(Approved by U. S. Census and American Association.)

Statement of Occupation.—Precise occupation is very important, so the healthfulness of various pursuits can be questioned applies to each and every period of age. For many occupations a term on the first line will be sufficient, e. g., *Planter, Physician, Composer, Architective Engineer, Civil Engineer, Stationary*. But in many cases, especially in industries, it is necessary to know (a) the nature and also (b) the nature of the business and therefore an additional line is preferred; it should be used only in the latter statement; it should be used only in the latter statement. As examples: (a) *Spinner*, (b) *Cotton man*, (c) *Grocery*; (a) *Foreman*, (b) *Factory*. The material worked on may be stated in a second statement. Never return "Lumberman," "Manager," "Dealer," etc., without precise specification, as *Day laborer, Laborer—Coal mine*, etc. Women at home engaged in the duties of the household should be stated as *Housekeepers* who receive a definite salary, or *Housewife, Housework* for children, not gainfully employed, as *at home*. Care should be taken to report the occupations of persons engaged in service for wages, as *Servant, Cook*, etc. If the occupation has been changed on account of the DISEASE CAUSING DEATH at beginning of illness. If retirement, that fact may be indicated thus (*tired, 6 yrs.*) For persons who have no occupation, write *None*.

Statement of Cause of Death.

the DISEASE CAUSING DEATH (the primary disease 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 neoplasma); *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 give 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.

5 COLOR RACE	5 SINGLE, MARRIED, WIDOWER, OR DIVORCED (write the word)	17 DATE OF DEATH (month, day, and year)	19	
			17	19
AL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH		
No. (plates of Rhode Island)		City or town where death occurred		
St.		Ward		
How long in U. S. (If of foreign birth?)		City or town and State)		
Yrs.		Yrs.		
mos.		mos.		
ds.		ds.		