

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

7230
7570

1. PLACE OF DEATH

County Sealstead Registration District No. 810 File No. _____
Township Union Primary Registration District No. 6056 Registered No. 8
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Margaret Luella Alexander

(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. 10 ds. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 9, 1922

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10

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 _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Sealstead Co Mo

PARENTS

10. NAME OF FATHER John H Alexander

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

12. MAIDEN NAME OF MOTHER Gladys Keach

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

14. INFORMANT W E Alexander (Address) Memphis Mo

15. MAR 7 - 1922 E F Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-18 19 22

17. I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1922, to Feb 18, 1922 that I last saw her alive on Feb 18, 1922 and that death occurred, on the date stated above, at 3:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spasms

ISC
9 1/2 (duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) Acute Indigestion
(duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at Home

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. E. Alexander, M. D.

Feb 18 1922 (Address) Memphis 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 Memphis Mo DATE OF BURIAL 2/19/ 1922

20. UNDERTAKER D W Payne & Son ADDRESS Memphis

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, Composer, 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 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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Feb. 1923

1 PLACE OF DEATH
 County, Scotland State MISSOURI 810 Registered No. _____
 Township Union or Village 6856 or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Maxine Lucille Alexander
 (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 Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____
 6 DATE OF BIRTH (month, day, and year) Feb 9 1917
 7 AGE Years _____ Months 10 Days _____ If LESS than 1 day, - hrs. or - min.

16 DATE OF DEATH (month, day, and year) Feb 18 1923
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 that I last saw h_____ alive on _____, 19____
 and that death occurred, on the date stated above, at _____m.
 The CAUSE OF DEATH* was as follows:

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.
 18 Where was disease contracted _____ if not at place of death? _____
 Did an operation precede death? _____ Date of _____

9 BIRTHPLACE (city or town) _____ (State or country) _____

10 NAME OF FATHER _____
 11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____
 12 MAIDEN NAME OF MOTHER _____
 13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

Was there an autopsy? _____
 What test confirmed diagnosis? _____
 (Signed) _____, M. D.
 _____, 19 (Address) _____
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14 Informant _____ (Address) _____

19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL 2/19 1923

15 Filed 3/7 1923 E. E. Parish REGISTRAR
 11-2184

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTAL

CRUCIAL. Do not write in blank spaces, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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