

PLACE OF DEATH

County BarryTownship Pioneer Capps Creek

Village _____

City _____

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 608File No. 70 2496Primary Registration District No. 5041

Registered No. _____

St.: _____ Ward)

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

FULL NAME Martha Jane Ferguson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH May The 22, 1850
(Month) (Day) (Year)AGE 71 9 27
73 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

OCCUPATION (a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Washington Co OhioNAME OF FATHER J.W. FergusonBIRTHPLACE OF FATHER (City or town, State or foreign country) UnknownMAIDEN NAME OF MOTHER Rebecca Reckall BuseBIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel W Ferguson(ADDRESS) Pioneer MoFiled Mar 26 1922R. A. Parnell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 19, 1922
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from May 18, 1922 to March 18, 1922, that I last saw her alive on March 18, 1922 and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bones
27A20 (Duration) 2 yrs. mos. ds.Compulsory Pyemia (SECONDARY) (Duration) yrs. 2 mos. ds.(Signed) S. Russell M. D.
March 20 1922 (Address) Fairview Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 _____

PLACE OF BURIAL OR REMOVAL Genevieve Mo DATE OF BURIAL Mar 20, 1922UNDERTAKER J. H. White ADDRESS Fairview Mo

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

PLACE OF DEATH

County.....
 or
 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)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX..... **COLOR OR RACE**.....
 SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH..... (Month)..... (Day)..... (Year).....
 I HEREBY CERTIFY, that I attended deceased from

AGE..... yrs..... mos..... ds.
 If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE
 (City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant).....

(ADDRESS).....

Filed..... 191.....
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH..... (Month)..... (Day)..... (Year).....
 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:

(Duration)..... yrs..... mos..... ds.
Contributory
 (SECONDARY)
 (Duration)..... yrs..... mos..... ds.
 (Signed)..... M. D., 191..... (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
 Where was disease contracted if not at place of death?
 Former or usual residence.....

PLACE OF BURIAL OR REMOVAL.....
DATE OF BURIAL..... 191.....
UNDERTAKER.....
ADDRESS.....

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

1. PLACE OF DEATH

County Barry Registration District No. 30 File No. 70
 Township Cropps Creek Primary Registration District No. 5041 Registered No. 34
 City (No. _____) St. _____ (Ward _____)

2. FULL NAME

Mattha Jane Ferguson
 (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

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) May 22 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 9 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (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) Washington Ohio

10. NAME OF FATHER

J. W. Ferguson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER

Rebecca Bruce

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14. INFORMANT

(Address) Samuel W. Ferguson
Pioneer St.

15. FILED

6-5-1922 H. M. West REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 19 1922

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tuberculosis of Bowels
 (duration) 2 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

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) S. C. Russell, M. D.
 , 19____ (Address) Paineville 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

Carmina Mo. DATE OF BURIAL Mar 20 1922

20. UNDERTAKER

J. A. White ADDRESS Paineville Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

THIS SHALL NOT BE RECEIVED A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

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

7496
"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: "Certificate 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.