

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

1. PLACE OF DEATH

County Henry
 Township Weyburn
 City (No.)

Registration District No. 353
 Primary Registration District No. 570510

File No. 8421^a
 Registered No.
 St. Ward

2. FULL NAME

Clarrissa Moore

(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 30 yrs. 0 mos. 7 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 6 1922

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

17. I HEREBY CERTIFY That I attended deceased from 2-12-22 to Mar 6, 1922 and that I last saw her alive on Mar 6, 1922 and that death occurred, on the date stated above, at 4 p.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1923-03-06

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1923 - acute cerebral hem

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 10 14

1922-3-6
82-A 85 16 14 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 1896 4 22 (duration) yrs. mos. ds.

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

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

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

DID AN OPERATION PRECEDE DEATH?

8-14

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.
 , 19 (Address)

X PARENTS 10. NAME OF FATHER Mason

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

12. MAIDEN NAME OF MOTHER Ann Collins

X PARENTS 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

*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.)

14. INFORMANT George Moore
 (Address) Wreck Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Norris Cemetery DATE OF BURIAL 3-8 1922

15. FILED 19..... REGISTRAR

20. UNDERTAKER J.P. Smith ADDRESS Wreck Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Cause of death should be carefully supplied.

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 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, OF 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.

1 PLACE OF DEATH

County

Henry

Township

Bingard

Village

City

(No. _____)

St.; _____

Ward) _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS353
548513

STANDARD CERTIFICATE OF DEATH

Registered No. _____

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

2 FULL NAME

L. Carriena Moore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

W

6 DATE OF BIRTH

X

(Month)

(Day)

X

(Year)

7 AGE

if LESS than
1 day, hrs.
or mln. ?

..... yrs. mos. ds.

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

PARENTS

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15

Filed 3/24 1923

Ed. C. Pugh

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 6

(Month)

(Day)

1922
(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:

(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.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.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS

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