

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

13077

1. PLACE OF DEATH

County Lincoln Registration District No. 486 File No. _____
 Township _____ Primary Registration District No. 4293 Registered No. 10
 City Osberry (No. _____) St. _____ Ward _____

2. FULL NAME

Mrs. Dennis Margaret Graves
 Residence No. _____ Ward _____ (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 14 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
38 1 1

8. OCCUPATION OF DECEASED (ED)
 (a) Trade, profession, particular kind of work Housework
 (b) General nature of business, or establishment which employed (or employed) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) V.A.

10. NAME OF FATHER Massie

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

12. MAIDEN NAME OF MOTHER Foley

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

14. INFORMANT Jos. Graves
 (Address) St Louis Mo

15. FILED Apr 16 1922 C.E. Powell
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1922

17. I HEREBY CERTIFY, That I attended deceased from March 12th 1922 to Apr 15 1922
 that I last saw him alive on Apr 15 1922, and that death occurred, on the date stated above, at 1130 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Enterocolitis

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

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) A. M. Taylor, M. D.
 , 19 (Address) Osberry, 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 Osberry Cemetery DATE OF BURIAL 4/18 1922
 20. UNDERTAKER W. W. Bradley ADDRESS Osberry

WRITE PLAINLY, WITH UNFADING INK. DO NOT WRITE IN RED INK. DO NOT WRITE IN PENCIL. DO NOT WRITE IN BLUE INK. DO NOT WRITE IN GORE. DO NOT WRITE IN OIL. DO NOT WRITE IN CHALK. DO NOT WRITE IN CRAYON. DO NOT WRITE IN PASTE. DO NOT WRITE IN GLUE. DO NOT WRITE IN RESIN. DO NOT WRITE IN WAX. DO NOT WRITE IN SOAP. DO NOT WRITE IN LIME. DO NOT WRITE IN SALT. DO NOT WRITE IN SUGAR. DO NOT WRITE IN OIL. DO NOT WRITE IN CHALK. DO NOT WRITE IN CRAYON. DO NOT WRITE IN PASTE. DO NOT WRITE IN GLUE. DO NOT WRITE IN RESIN. DO NOT WRITE IN WAX. DO NOT WRITE IN SOAP. DO NOT WRITE IN LIME. DO NOT WRITE IN SALT. DO NOT WRITE IN SUGAR.

N. B.—Every item of information should be carefully supplied. It should be stated, if possible, whether the cause of death is a disease, an injury, or a violence. If the cause of death is a disease, it should be stated whether it is a communicable disease, and if so, what is the name of the disease. If the cause of death is an injury, it should be stated whether it is a violent injury, and if so, what is the name of the injury. If the cause of death is a violence, it should be stated whether it is a violent violence, and if so, what is the name of the violence. If the cause of death is a disease, it should be stated whether it is a communicable disease, and if so, what is the name of the disease. If the cause of death is an injury, it should be stated whether it is a violent injury, and if so, what is the name of the injury. If the cause of death is a violence, it should be stated whether it is a violent violence, and if so, what is the name of the violence. If the cause of death is a disease, it should be stated whether it is a communicable disease, and if so, what is the name of the disease. If the cause of death is an injury, it should be stated whether it is a violent injury, and if so, what is the name of the injury. If the cause of death is a violence, it should be stated whether it is a violent violence, and if so, what is the name of the violence.

Rei

[Appr.]

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

obar pneumonia; *Broncho-unqualified*, is indefinite); *inges, peritoneum*, etc., of (name or definite; avoid use of "Tumor" for malignant neoplasms) *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial*, etc. The contributory (secondary or in- affection need not be stated Example: *Measles* (disease causing death), *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.