

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

✓
 File No. 32038^a
 Registered No. 22

1. PLACE OF DEATH

County St. Charles Registration District No. 664
 Township Green Ridge Primary Registration District No. 5882
 City (No. _____) St. _____ Ward _____

2. FULL NAME

Lucinda Frank
 (a) Residence No. _____ St. _____ Ward _____
 (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. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robt Frank

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27-1839

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 | 6 | 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) Govt
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Charles Rogers

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

12. MAIDEN NAME OF MOTHER Elizabeth Chilton

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

14. INFORMANT (Address) Robt Frank Windsor Mo

15. Filed 12-20-22 1922 Ch. P. Shelby REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 3 1922

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1922, to Nov 3, 1922, that I last saw her alive on Nov 3, 1922, and that death occurred, on the date stated above, at Nov 4, 9:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
131

CONTRIBUTORY (SECONDARY) Old age (duration) 3 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) G. W. Head, M. D.

, 19 (Address) Windsor, 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 Windsor Mo. DATE OF BURIAL Nov. 5 1922

20. UNDERTAKER W. E. Huston ADDRESS Windsor Mo.

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, 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.

with Nov 4

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

1. PLACE OF DEATH

County Pettis Registration District No. 664 File No. _____
Township Sum Ridge Primary Registration District No. 5882 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Lucinda Fink
(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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 28 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
89 | 6 | 6

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Arbely Rogers

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

12. MAIDEN NAME OF MOTHER Elizabeth Chilton

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

14. INFORMANT Robert Fink (Address) Windsor mo

15. FILED Dec 20 1922 A. P. Shelly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 4th 1922

17. I HEREBY CERTIFY, That I attended deceased from Oct 1922, to Nov 9th 1922, that I last saw her alive on Nov 3rd 1922, and that death occurred, on the date stated above, at Windsor Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Old Age
(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) C. W. Head, M. D.
, 19 (Address) Windsor 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 Windsor MO DATE OF BURIAL Nov 3rd 1922

20. UNDERTAKER W. E. Houston ADDRESS Windsor, MO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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32038-A
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