

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

35-015-a  
3/20/23

PLACE OF DEATH  
County Moniteau  
Township Pilot Grove Registration District No. 577 File No. \_\_\_\_\_  
or \_\_\_\_\_  
Village Lathrop Primary Registration District No. 5775 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 Melissa Jane Cox

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>widowed</u> (Write the word)	DATE OF DEATH <u>Dec 30</u> , 19 <u>22</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Jan. 9 - 1839</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Dec 25</u> , 19 <u>22</u> , to <u>Dec 30</u> , 19 <u>22</u> , that I last saw <u>her</u> alive on <u>Dec 30</u> , 19 <u>22</u> , and that death occurred, on the date stated above, at <u>59</u> m.	
AGE <u>83</u> yrs. <u>11</u> mos. <u>20</u> ds.		IF LESS than 1 day, ____ hrs. or ____ min.?	The CAUSE OF DEATH* was as follows: <u>Stroke, probably fall, fall and break hip.</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>186A</u>			(Duration) ____ yrs. ____ mos. <u>5</u> ds.	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>194B</u>			Contributory (Duration) ____ yrs. ____ mos. ____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Glasgow, Ky.</u>			(Signed) <u>J. M. Robertson</u> M. D. <u>Dec 2</u> , 19 <u>22</u> (Address) <u>Lathrop</u>	
PARENTS	NAME OF FATHER <u>William Payne</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER <u>Melissa White</u>		At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)		Where was disease contracted if not at place of death?	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. W. T. Lathrop</u>			Former or usual residence _____	
(ADDRESS) <u>California</u>			PLACE OF BURIAL OR REMOVAL <u>Green Grove</u>	
Filed _____ 19 <u>23</u>			DATE OF BURIAL <u>Dec 31</u> , 19 <u>23</u>	
REGISTRAR			UNDERTAKER <u>J. Bowlin &amp; Son</u>	
			ADDRESS <u>California</u>	

# 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*, *peritonaeum*, etc., *Carcinoma*, *Sar-*

*coma*, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)



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M. 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. See instructions on back of certificate.

1 PLACE OF DEATH

County Monteau  
Township Pilot Grove  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

577  
5775

State of \_\_\_\_\_

Registered No. \_\_\_\_\_

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

2 FULL NAME Melissa Jane Coy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) W

6 DATE OF BIRTH Jan 9 1839  
(Month) (Day) (Year)

7 AGE 83 yrs. 11 mos. 20 ds.  
If LESS than 1 day, --- hrs. OR --- min. ?

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

9 BIRTHPLACE (State or country)

PARENTS  
10 NAME OF FATHER  
11 BIRTHPLACE OF FATHER (State or country)  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_

15 Filed Dec 30 1927 R. H. Latham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 30 1927  
(Month) (Day) (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:

Contributory \_\_\_\_\_ (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 \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

35015-A

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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.