

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

1. PLACE OF DEATH

County Luningston Registration District No. 5-11 File No. 1779
 Township Fairview Primary Registration District No. 5-6-80 Registered No. 13
 City (No.) St. Ward

2. FULL NAME Mary A Mustar

(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 unknown 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) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charley Mustar
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 10
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 4 4

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

10. NAME OF FATHER Z. Mann

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

12. MAIDEN NAME OF MOTHER Mary Johnson

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

14. INFORMANT C. Harley Hickman
 (Address) R.F.D. Bedford, Mo.

15. FILED Jan 15 1923 Mrs. Chas. Ludwig
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 19 23
 17. I HEREBY CERTIFY, That I attended deceased from Jan 12 19 23 to Jan 11 19 23
 that I last saw her alive on Jan 11 19 23, and that death occurred, on the date stated above, at 1 1 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio-sclerosis

97 (duration) 7 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY)

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) A. Collier, M. D.
Jan 12, 1923 (Address) Chillicothe 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 Burrowside Cem DATE OF BURIAL 19

20. UNDERTAKER F. B. Norman Chillicothe ADDRESS

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, callulitis, 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 Livingston
 Township Wainview
 or
 Village _____
 or
 City _____ (No. _____ St.; _____ Ward)

571
5680

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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 Mary A. Mustar

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH May 10 1843
(Month) (Day) (Year)

7 AGE 80 yrs. X mos. X ds. If LESS than 1 day, X hrs. or min.?

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) _____

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 Jan 15 1923 Mrs. Charles Ludwig REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 11 1923
(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: _____

_____, (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____, (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____, M. D.

_____, 191____ (Address) _____

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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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1779