

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

1930

1. PLACE OF DEATH

County New Madrid Registration District No. 605 File No. _____
Township Wrenco Primary Registration District No. 5804 Registered No. 4
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Gracie Gu. McFarlin

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

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 31 19 23

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at Jan. 31 7am.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tuberculosis, Lat

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 27 1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
17. 10 6.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer None

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

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Township Mo

18. WHERE WAS DISEASE CONTRACTED? At Residence
NOT AT PLACE OF DEATH? Yes

DID AN OPERATION PRECEDE DEATH? _____

10. NAME OF FATHER N. Hicks F.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Fredrick town Mo

12. MAIDEN NAME OF MOTHER Mandy Bloss

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

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFINED TO? (Signature) Edith Edgington M.D.
, 19____ (Address) Parsons 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.)

14. INFORMANT (Address) Edith Edgington

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Hillion DATE OF BURIAL 2/1 19 23

15. FILED 1-31-23 Edith Edgington REGISTRAR

20. UNDERTAKER Em Hill ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, Composer, 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 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," "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.

PLACE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSCounty New Madrid

STANDARD CERTIFICATE OF DEATH

Township Como

Village _____

City _____ (No. _____ St.; _____ Ward)

605
5804 State of _____Registered No. 4

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

FULL NAME Gracie Lee McFarlin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M6 DATE OF BIRTH Mar 25, 1915
(Month) (Day) (Year)7 AGE 17 yrs. 10 mos. 6 ds. If LESS than 1 day, --- hrs. or --- min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) County mo10 NAME OF FATHER N. Hurst11 BIRTHPLACE OF FATHER (State or country) Fredericktown mo12 MAIDEN NAME OF MOTHER Mandy Glass13 BIRTHPLACE OF MOTHER (State or country) Ill

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David M. Phares
(Address) County mo15 Filed 1-31, 1923 Edith Edgington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 31, 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 7 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis31 no Physician (Duration) _____ mos. _____ ds.

Contributory (SECONDARY) _____

(Signed) Edith Edgington M.D. (Duration) _____ yrs. _____ mos. _____ ds.

_____, 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 Mount Gilman DATE OF BURIAL 2/1, 192320 UNDERTAKER L. M. Hill ADDRESS Parmar mo

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