

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

1923

1. PLACE OF DEATH  
 County Madison Registration District No. 625 File No.           
 Township          Primary Registration District No. 3031 Registered No. 3  
 City Marionville St.          Ward)         

2. FULL NAME E. Elizabeth Gross  
 (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. da. 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. G. Gross

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	56	11	18	82

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

9. BIRTHPLACE (CITY OR TOWN) Havanna  
 (STATE OR COUNTRY) Ill

10. NAME OF FATHER Geo. Hills

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

12. MAIDEN NAME OF MOTHER Charissa Edwards

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 9 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1923, to Jan. 9, 1923 that I last saw her alive on Jan. 9, 1923, and that death occurred, on the date stated above, at 10:20 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Euremia following  
myocardial infarction  
apoplexia  
 (duration) yrs. mos. da. 4

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage  
 (duration) yrs. mos. da. 3

18. WHERE WAS DISEASE CONTRACTED  
 NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH. no DATE OF.....  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS none  
 (Signed) H. M. Minton, M. D.  
 , 19 (Address) Marionville

\*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 W. G. Gross  
 (Address) Marionville, Mo

15. FILED Jan 10 1923 C. P. Fryer (E. Ray)  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill Marionville DATE OF BURIAL 1-11 1923

20. UNDERTAKER Communist Way Marionville  
 ADDRESS         

F. 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.

*19. Minton*

# 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 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.

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

D. D.—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 Nadaway

625  
3031

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

Township \_\_\_\_\_

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

Village \_\_\_\_\_

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

City Marysville (No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward \_\_\_\_\_

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

2 FULL NAME Elizabeth Grace

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Jan 9 1923  
(Month) (Day) (Year)

6 DATE OF BIRTH X Jan 22 1866  
(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.

7 AGE - \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. ?

The CAUSE OF DEATH\* was as follows:

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9 BIRTHPLACE (State or country) \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_

10 NAME OF FATHER \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

\_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (State or country) \_\_\_\_\_

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) \_\_\_\_\_

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Address) \_\_\_\_\_

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

15 \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

Filed Jan 10 1923 C. P. Fryer (E. Ray) REGISTRAR

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

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