

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

2098

1. PLACE OF DEATH

Comy. Pike
Township Wore
City Wore (No.)

Registration District No. 684
Primary Registration District No. 4408

File No.
Registered No. 3
St. Ward

2. FULL NAME Alice L. Davis

(a) Residence No. St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 30 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 M F
4. COLOR OR RACE W O
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M W D V

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OR (OR) WIFE OF M. J. Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 17 - 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 5 23

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)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lafayette Co. Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Charles Netie

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

12. MAIDEN NAME OF MOTHER Susan Rodgers

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

14. INFORMANT W J Davis
(Address) Bowling Green Mo

15. FILED 2/10 23 W. B. Coomer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 19 23

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1922, to Jan 10 1923, that I last saw her... alive on Jan 8 1923, and that death occurred, on the date stated above, at 8 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia the result of Influenza

CONTRIBUTORY (SECONDARY) H B
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) W. W. Trusley M. D.

, 19 (Address) Bowling Green Mo

*State the DISEASE CAUSING DEATH, or in death 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 Bowling Green Cemetery DATE OF BURIAL Jan 12 19 23

20. UNDERTAKER H. B. Coomer ADDRESS Bowling Green 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*, *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.

OCT 3 1945

1 PLACE OF DEATH

County PikeTownship Cuire

Village _____

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of _____

Registered No. _____

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

2 FULL NAME Allie L Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♂ 4 COLOR OR RACE M 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married6 DATE OF BIRTH July 17, 18497 AGE 73 yrs. 5 mos. 23 ds. If LESS than 1 day, ____ 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) _____

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 2/10 23 W. A. ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 10, 1923

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) _____

* 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 _____

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OCT - 4 1945