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

Vot. Pct. Mur 8 & 11

Inc. Town Wolf Island

City ~~Medley Mo~~

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 567

Primary Registration District No. 5767

File No. 3854 B

Registered No. 15

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

(No. St., Ward)

2 FULL NAME Louisa Dixson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed or Divorced (Write the word): Widow

6 DATE OF BIRTH: Feb 24 (Month) (Day), 1833 (Year)

7 AGE: 90 yrs. mos. ds.

IF LESS than 1 day ____ hrs. or ____ min?

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

9 BIRTHPLACE (State or country): Cont Mo

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) J W Mercer

(Address) Medley Mo

15 Filed 4/9, 1923 Cuff M Hodges Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 24, 1923. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923, to Feb 23, 1923, that I last saw her alive on Feb 23, 1923, and that death occurred on the date stated above at 1300 m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Hypertrophy

(Duration) Don't Know yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible], M. D.

Feb 24, 1923. (Address) Hickman Ky

*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: Gray Cem Mo

DATE OF BURIAL: 2/25, 1923

20 UNDERTAKER: W Lowe Funeral Co

ADDRESS: Wickliffe Ky

11—3184

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

roved by U. S. Census and American Public Health Association

atement of occupation.—Precise statement of occu-
on is very important, so that the relative healthful-
of various pursuits can be known. The question
lies to each and every person, irrespective of age.
many occupations a single word or term on the
line will be sufficient, e. g., *Farmer* or *Planter*,
ian, Compositor, Archi[illegible] *Locomotive engin-*
ivil engineer, Stationar[illegible], etc. But in
cases, especially in industrial employments, it is
ary to know (*a*) the kind of work and also (*b*) the
of the business or industry, and therefore an
onal line is provided for the latter statement; it
l be used only when needed. As examples: (*a*)
er, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;*
oreman, (*b*) *Automobile factory.* The material
ed on may form part of the second statement.
r return "Laborer," "Foreman," "Manager,"
ler," etc., without more precise specification, as
laborer, Farm laborer, Laborer—Coal mine, etc.
en at home, who are engaged in the duties of the
hold only (not paid housekeepers who receive a
salary), may be entered as *Housewife, House-*
At home, and children, not gainfully employed,
ool or *At home.* Care should be taken to re-
cifically the occupations of persons engaged in
service for wages as *Servant, Cook, House-*
tc. If the occupation has been changed or given
account of the DISEASE CAUSING DEATH, state
ion at beginning of illness. If retired from bus-
hat fact may be indicated thus: *Farmer (retired*
For persons who have no occupation whatever,
one.

ment of cause of death.—Name, first, the DIS-
CAUSING DEATH (the primary affection with re-
time and causation) using always the same ac-
term for the same disease. Examples: *Cerebro-*
fever (the only definite synonym is "Epidemic
spinal meningitis"); *Diphtheria* (avoid use of
"); *Typhoid fever* (never report "Typhoid
onia"); *Lobor pneumonia; Bronchopneumonia*
monia," unqualified, is indefinite); *Tuberculo-*
ungs, meninges, peritonaeum, etc., Carcinoma,
na, etc., of .....(name origin; "Cancer"
definite; avoid use of "Tumor" for malignant
sms); *Measles; Whooping Cough; Chronic valv-*
art 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," "Hemorrhage," "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 [illegible]," 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."

NOTE.—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, pyaemia, septicaemia, tetanus.

Form V. S. 1—125m—6
-19-19
COMMONWEALTH OF KENTUCKY

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Mississippi State MISSOURI. 567 Registered No. ____
Township ____ or Village 5767 or
City Wolf Island No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Luisa Duson

(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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.

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

9 BIRTHPLACE (city or town) ____
(State or country)

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

14 Informant ____
(Address)

15 Filed 4/9, 1923 Dr. Duff M. Hodges
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

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 ____ m.
The CAUSE OF DEATH* was as follows:
Uraemia was caused from acute nephritis with symptoms of cardiac dysfunction (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) ____
(duration) ____ yrs. ____ mos. ____ ds.

128

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) ____, M. D.
, 19 (Address)

* 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	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

SUPPLEMENTAL

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.

11—3184

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 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.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

58854-B