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

6066

1. PLACE OF DEATH
County Perry — Registration District No. 662 — File No.
Township Salem — Primary Registration District No. 5880 — Registered No. 3
City (No. St. Ward)

2. FULL NAME Arenia Louise Farrar
(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: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

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

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

7. AGE — YEARS — MONTHS — DAYS: 10 — 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) Menfro Mo
(STATE OR COUNTRY) Perry Co Mo

PARENTS
10. NAME OF FATHER Frank Farrar
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Menfro Mo
(STATE OR COUNTRY) Perry Co Mo
12. MAIDEN NAME OF MOTHER Martha Wischem
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Perry Co Mo

14. INFORMANT Frank Farrar
(Address) Menfro Mo

15. FILED 2-3, 1923 J. F. DeLassus REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 3rd 1923

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1923, to Feb 3rd, 1923 that I last saw her alive on Feb 2, 1923 and that death occurred, on the date stated above, at 4 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
11A
104A (duration) yrs. mos. 3 ds.
CONTRIBUTORY (SECONDARY) Cold
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH? Menfro Mo
DID AN OPERATION PRECEDE DEATH? DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. H. Abernathy, M. D.
2-3, 1923 (Address) Menfro 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: Crosstown Mo — DATE OF BURIAL: Feb 4 1923
20. UNDERTAKER — ADDRESS

N. 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.

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 nephr*[illegible], etc. The contributory (secondary or intercurr[illegible] affection need not be stated unless important. [illegible]mple: *Measles* (disease causing death), 29 *ds.;* [illegible]*onchopneumonia* (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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Perry State MISSOURI. 662 Registered No. ____
Township Salem or Village 5880 or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Aremia Louise Farrar

(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.

SUPPLEMENTAL

PERSONAL AND STATISTICAL PARTICULARS

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

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

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1923

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 2-2, 1923 J. F. DeLassus
REGISTRAR

11—2184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 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:

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY ____
(SECONDARY)
____ (duration) ____ yrs. ____ mos. ____ ds.

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 No Undertaker ADDRESS ____

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

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

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