

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

*John M. Reid*  
6007

1. PLACE OF DEATH  
 County Lebanon Registration District No. 668 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3032 Registered No. 58  
 City Lebanon (N) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mary Jane Lockley  
 (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, 17 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE W SINGLE, MARRIED, WIDOWED OR DIVORCED Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 16-1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
81 9

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

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

10. NAME OF FATHER James Jones

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

12. MAIDEN NAME OF MOTHER Elegatha J. Mombse

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

14. INFORMANT (Address) [Signature]

15. FILED Oct 27, 1923 J. G. Lee REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1923 to Feb 24 1923  
 that I last saw h. or alive on Feb 23 1923, and that death occurred, on the date stated above, at 8 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic unobstructed nephritis  
131  
97  
167 Over 1000 yrs. mos. da.  
 CONTRIBUTORY arterio sclerosis & scale arteries  
 (SECONDARY) arterio sclerosis yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chine Examination  
 (Signed) Chapman, M. D.

\*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 Pleasant Hill DATE OF BURIAL Feb 27 1923

20. UNDERTAKER M. Laughlin Bros ADDRESS Lebanon Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHN. 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 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.

# STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

**1 PLACE OF DEATH**  
 County Pettis State MISSOURI 668 Registered No. \_\_\_\_\_  
 Township \_\_\_\_\_ or Village 3032 or \_\_\_\_\_  
 City Sedalia No. \_\_\_\_\_ St., \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

**2 FULL NAME** Mary Jane Licklider  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

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

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

I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

**6 DATE OF BIRTH** (month, day, and year) Sept 16 1857

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_

**7 AGE** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

**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 \_\_\_\_\_

**CONTRIBUTORY** (SECONDARY) \_\_\_\_\_

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

**9 BIRTHPLACE** (city or town) \_\_\_\_\_  
 (State or country) \_\_\_\_\_

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

**18** Where was disease contracted \_\_\_\_\_

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

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

Was there an autopsy? \_\_\_\_\_

**11 BIRTHPLACE OF FATHER** (city or town) \_\_\_\_\_  
 (State or country) \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

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

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

, 19 (Address) \_\_\_\_\_

**13 BIRTHPLACE OF MOTHER** (city or town) \_\_\_\_\_  
 (State or country) \_\_\_\_\_

\* 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** Mrs A B Irwin  
 (Address) Sedalia Mo.

**19 PLACE OF BURIAL, CREMATION, OR REMOVAL** Pleasant Green Cem.

**DATE OF BURIAL** Feb 27 1923

**15 Filed** Feb 27, 1923 J G Love

**20 UNDERTAKER** M<sup>c</sup>Laughlin Bros

**ADDRESS** Sedalia

THIS IS A PERMANENT RECORD. Every death should be reported to the local health officer. 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.

SUPPLEMENTAL

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

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BY PHYSICIAN.

1907