

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

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1. PLACE OF DEATH

County Putnam Registration District No. 718 File No. 6181
 Township Unionville Primary Registration District No. 6430 Registered No. 48
 City Unionville St. _____ Ward _____

2. FULL NAME

Mary Jane Leonard
 (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. da.

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 or (OR) WIFE OF George Leonard
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) March-25-84
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 75 11 1
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House work
 (b) General nature of industry, business, or establishment in which employed (or employer) House work
 (c) Name of employer _____

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-26 1923
 17. I HEREBY CERTIFY That I attended deceased from Nov-11 1922 to Feb-26 1923, and that I last saw her alive on Oct-26 1923, and that death occurred, on the date stated above, at 10 P.M.

7. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis (Cerebral)
 (duration) 3 yrs. mos. da.
 CONTRIBUTORY Accident (fall from stairs)
 (SECONDARY) 201 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____
 WAS THERE AN AUTOPSY: _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

10. NAME OF FATHER

David Leonard

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER

Lucinda Hill

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tenn

14. INFORMANT

(Address) Mrs Effie Hognes Unionville Mo

15. FILED

2/29 23 J. H. Hudson REGISTRAR

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Wm. Preston Fore M. B.
 (Address) Unionville Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Unionville Mo

DATE OF BURIAL

2-28-23

20. UNDERTAKER

D. W. Comstock Unionville Mo

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*, *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, 8 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.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Feb. 3. 23

Fracture was due to fall; whether fall was due to cerebral hemorrhage or to general muscular asthenia I am unable to state. Patient remained semi-comatose from the date of injury until date of death.

Wm. W. W. W.

RR

Mary Jane Leonard

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

The enclosed certificate is defective for the reason that the kind of accident or means of injury is not stated.

Please correct and return, together with this card, in the enclosed stamped envelope.

W. D. L. [Signature]
~~FRANK B. SMITH~~
State Registrar

DR. CORTNEZ F. ENLOE,

~~State Registrar~~

~~State Registrar~~

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Putnam State MISSOURI Registered No. 718
 Township _____ or Village 6430 or _____
 City Unionville No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Jane Leonard
 (a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
 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.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH (month, day, and year) Feb 26 1923

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

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____,

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

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

7 AGE Years _____ Months _____ Days _____
If less than 1 day, hrs. or min.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

Acc. Frac. Femur

(b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

(duration) _____ yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) (duration) _____ 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) Wm. B. ..., 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.)

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) _____

19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

15 Filed 2/27 1923 H. ...
 REGISTRAR

20 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 OCCURRENCE 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.