

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

*P. 202*  
*6247*  
*5*  
*6*

1. PLACE OF DEATH  
 County Rosley Registration District No. 750 File No. 5  
 Township Shelby Primary Registration District No. 6246 Registered No. 516  
 City Groebel St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Groebel C. Hollandsworth  
 (a) Residence. No. Dempham Mo. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, YEAR) March 20 - 1863

7. AGE      YEARS      MONTHS      DAYS      IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
60      -      -      -

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

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY, YEAR) Feb. 5 1923

17. I HEREBY CERTIFY That I attended deceased from Nov 22 1922 to Feb 5 1923 that I last saw her alive on Feb 4 1923 and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Heart failure  
720  
750  
 CONTRIBUTORY (SECONDARY) auricular fibrillation  
 (duration)      yrs.      mos.      ds.  
 (duration)      yrs.      mos.      ds. 2

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Beaumont Ill.

10. NAME OF FATHER James Stockdale

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

12. MAIDEN NAME OF MOTHER Martha Cutting

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) C. B. Johnston M. D.  
 Address Dempham 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.)

14. INFORMANT J. M. Hollandsworth  
 (Address) Dempham, Mo.

15. FILED 26 6 23 E. B. Johnston  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oxford DATE OF BURIAL 2-6-1923

20. URBERTAKER J. C. Wright ADDRESS Dempham Mo.

WRITE PLAINLY

N. B.—Every item of information should be stated EXACTLY. PHYSICIAN'S SIGNATURE SHOULD BE PLAINLY WRITTEN IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is required.

# 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.

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

**1. PLACE OF DEATH**

County Ripley Registration District No. 750 File No. ....  
 Township ..... Primary Registration District No. 6246 Registered No. ....  
 City ..... (No. ....) St. .... Ward)

**2. FULL NAME** Phoebe C. Hollandsworth

(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>		
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 2-6 1923 E. B. Johnston REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 5 - 19 23

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19..... that I last saw h....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Heart failure  
mitral regurgitation  
 (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	ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be stated EXACTLY. PHYSICIAN'S SIGNATURE IMPORTANT. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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