

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County James Registration District No. 809 File No. _____
Township Beaumont Primary Registration District No. 2126 Registered No. 2
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Laura Brown
(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
6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 46
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Ark

10. NAME OF FATHER James Swallen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ark
12. MAIDEN NAME OF MOTHER Mattie Carter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ark

14. INFORMANT (Address) _____

15. FILED 3-9 19 23 C. G. James REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-16 1923

17. I HEREBY CERTIFY That I attended deceased from 2-1 1923, to 2-16 1923 that I last saw him _____ alive on _____ 19____, and that death occurred, on the date stated above, at 2-16 m. 2-3

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

CONTRIBUTORY (SECONDARY)

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?

(Signed) Dr. George Steyer M. D.

, 19 (Address) Proton 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 Proton Cemetery DATE OF BURIAL 2-17 1923

20. UNDERTAKER James Proton ADDRESS Proton

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

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

2. FULL NAME

(a) Residence, No....., St....., Ward.....
Length of residence in city or town where death occurred yrs. mos. da. Flow long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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)

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....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)....., 19.....

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. mos. da.

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 death 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

20. UNDERTAKER

ADDRESS

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County James State MISSOURI, 85-8 Registered No. _____
 Township Big Creek or Village 2126 or _____
 City _____ No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Laura Brown
 (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 <u>G</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>	16 DATE OF DEATH (month, day, and year) <u>Feb 16 1923</u>
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5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____, 19____, to _____, 19____,

6 DATE OF BIRTH (month, day, and year) not given
 7 AGE Years 46 Months 12 Days _____
IF LESS than 1 day, give hrs. and 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) _____

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 Protin, MD (Address) _____

15 Filed 3-9, 1923 W. A. James REGISTRAR
11-3184

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:

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
_____	_____

SUPPLEMENTAL

Exact statement of OCCUPATION may be properly classified. See instructions on back of certificate. This is very important.

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 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 symptom-

atic), "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.

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7673