

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

8158

1. PLACE OF DEATH
 County Caldwell Registration District No. 99 File No. 8158
 Township Polo Primary Registration District No. 4061 Registered No. 6
 City Polo (No. St. Ward)

2. FULL NAME Martha J. Belt
 (a) Residence, No. Polo Mo. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 3 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) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Benjamin Belt (Dead)
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 11, 1843
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 0 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
 (b) General nature of industry, business, or establishment in which employed (or employer) At home
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (?)
 (STATE OR COUNTRY) Wisconsin

10. NAME OF FATHER (?) Morgan
Franklin
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont Know
 (STATE OR COUNTRY) Dont Know (D. Virginia)
 12. MAIDEN NAME OF MOTHER Anna Underwood
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont Know
 (STATE OR COUNTRY) Illinois

14. INFORMANT Dr. G. Hornmedell
 (Address) 403 W. Springfield

15. FILED 3/27 23 R. E. Houch
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 26 1923
 17.

I HEREBY CERTIFY, That I attended deceased from March 26th 1923, to March 26 1923, that I last saw her alive on March 25 1923, and that death occurred, on the date stated above, at 1:00 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Gastritis
5-70
1190
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Advanced Cancer of the
uterus (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? Place of death

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) B. H. G. M. D., M. D.
 , 19 (Address) Polo 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 Colo Iowa DATE OF BURIAL 3/29 1923
Redeption
Yes

20. UNDERTAKER Call Carson & Sons ADDRESS Independence 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.

Artistic

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.

My dear

This is a case not of My
catarrh but observed occasionally
had been confined to bed for months
finally died from pure neglect
Tijim accumulated and caused acute
Gastritis

I understand that she was a
Merican and did not believe in a doctor

This is from inquiry

your B.H. Paris

8518

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Caldwell 99 State MISSOURI Registered No. _____
 Township _____ or Village _____ or
 City Polo No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Martha E Belt
 (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

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W
 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) Mar 26 19 23

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:
Acute Gastritis
from a toxin accumulation in the system from lack of attention
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Chronic arthritis of a
 (Secondary) deptic nature
 (duration) 1 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) B. F. Carr _____, M. D.
 _____, 19 (Address) _____

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

20 UNDERTAKER _____ ADDRESS _____

IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important. See instructions back of certificate.

SUPPLEMENTAL

HOSPITAL

112

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

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11-3184

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BY PHYSICIAN.

8518