

## PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty CaldwellTownship GrantRegistration District No. 99File No. 8139

Village \_\_\_\_\_

Primary Registration District No. 5146Registered No. 5City Boonville (NO \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Prudence Elizabeth Slack.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Married  
WIDOWED  
OR DIVORCED  
(Write the word)DATE OF BIRTH Jan 4th, 1851  
(Month) (Day) (Year)AGE 72 yrs. 2 mos. 20 ds. IF LESS than  
1 day, \_\_\_ hrs. or \_\_\_ min.?OCCUPATION  
(a) Trade, profession, or particular kind of work House-wife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_BIRTHPLACE  
(City or town, State or foreign country) Ray, Co, Mo.PARENTS  
NAME OF FATHER Joseph Grimes.  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.  
MAIDEN NAME OF MOTHER Julia Rainwater.  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Nellie Parnas  
(ADDRESS) Boonville MoFiled 3/25 23 1923 R. W. Mount REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 24, 1923  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Mch 18, 1923, to Mch 24th, 1923, that I last saw her alive on Mch 23th, 1923, and that death occurred, on the date stated above, at I. #0. A M  
The CAUSE OF DEATH\* was as follows:  
Appoplexy. Cerebral Hemorrhage.Contributory Atherosclerosis  
(SECONDARY) (Duration) 8 yrs. 8 mos. 8 ds.  
(Signed) R. W. Mount M. D.  
Mch 25 1923 (Address) Boonville Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted  
If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Boonville, Mo DATE OF BURIAL Mar 25, 1923  
UNDERTAKER Wm. H. Cowley ADDRESS Boonville Mo

# 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*, *Compositor*, *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, peritonaeum*, 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), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthénia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)

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CERTIFICATE OF DEATH

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERMANENT RECORD

1-PLACE OF DEATH

County Caldwell  
City Grant

Registration District No. 99 File No. 5146

Primary Registration District No. 706 Registered No. 5146

(NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Prudence Elizabeth Black

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Jan 4 1851  
(Month) (Day) (Year)

AGE 72 yrs. 2 mos. 20 ds.  
If LESS than 1 day: hrs. or min.?

OCCUPATION a) Trade, profession, or particular kind of work Housewife  
b) General nature of industry, business or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Ray Co Missouri

10 NAME OF FATHER Joseph Grimes

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee

12 MAIDEN NAME OF MOTHER Julia Ramwater

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Sallie Luman  
(Address) Polo Mo.

Filed July 1 1923 R L Mount  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 22 1923 to Mar 25 1923  
that I last saw her alive on Mar 25 1923

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH\* was as follows:  
Apoplexy

CONTRIBUTORY (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) R L Mount M. D.  
Mar 25 1923 (Address) Polo Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Ray DATE OF BURIAL Mar 25 1923  
Knexville Cem Co

20 UNDERTAKER Alsopugh Cowley ADDRESS Polo Mo.

# LOCAL REGISTRAR'S RECORD - DO NOT TEAR LEAF OUT

CERTIFICATE OF DEATH

County .....  
 Township ..... Registration District No. .... File No. ....  
 or .....  
 Village ..... Primary Registration District No. .... Registered No. ....  
 or .....  
 City ..... (NO) ..... St. .... Ward .....  
 (If death occurred in hospital or institution give its NAME last of street and number)

## 2 FULL NAME

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX ..... 5 SINGLE .....  
 4 COLOR OR RACE ..... 6 MARRIED .....  
 WIDOWED .....  
 OR DIVORCED .....  
 (Write the word)

8 DATE OF BIRTH ..... (Month) ..... 1 ..... (Day) ..... 1 ..... (Year)

7 AGE ..... yrs. .... mos. .... da. ....  
 If LESS than 1 day ..... hrs. ....  
 or ..... min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work .....  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....  
8159

9 BIRTHPLACE  
 (City or town, State or foreign country) .....  
 10 NAME OF FATHER .....  
 11 BIRTHPLACE OF FATHER .....  
 (City or town, State or foreign country) .....  
 12 MAIDEN NAME OF MOTHER .....  
 13 BIRTHPLACE OF MOTHER .....  
 (City or town, State or foreign country) .....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....  
 (Address) .....  
 15 Filed ..... 191 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... 191 ..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 191 ..... to ..... 191 ..... that I last saw h..... alive on ..... 191 ..... and that death occurred, on the date stated above, at.....  
 The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
 (Secondary) ..... yrs. .... mos. ....  
 (Signed) ..... (Duration) ..... yrs. .... mos. ....  
 ..... (Address) ..... M.

\*State the Disease Causing Death, or, in death from Violent Causes, (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicid

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
 At place of death ..... yrs. .... mos. .... ds. .... In the State ..... yrs. .... mos. ....  
 Where was disease contracted if not at place of death? .....  
 Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL ..... 191 .....  
 20 UNDERTAKER ..... ADDRESS .....

N. B. - Every item of information should be carefully classified, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

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