

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

8402

1. PLACE OF DEATH
 County Cooper Registration District No. 222 File No. 99
 Township Palist Primary Registration District No. 5303 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Margret Coffman
 (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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 11 1850
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 0 12
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work had no occupation
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____
9. BIRTHPLACE (CITY OR TOWN) Warsaw
 (STATE OR COUNTRY) Missouri
10. NAME OF FATHER William Doyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
 (STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER _____
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 23 1923
17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1923, to Mar 23 1923, that I last saw h. a. r. alive on Feb 23 1923, and that death occurred, on the date stated above, at 11 P. M.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of intestines
46 (duration) 1 yrs. 3 mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ ds.
18. WHERE WAS DISEASE CONTRACTED 45
 IF NOT AT PLACE OF DEATH. _____
8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) W. B. Barnes, M. D.
Feb 23, 1923 (Address) Pilot Grove 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 Arthur Coffman
 (Address) Pilot Grove Mo
15. FILED 2/24 1923 Chas. H. Tomlinson REGISTRAR
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pilot Grove Mo **DATE OF BURIAL** Mar 25 1923
20. UNDERTAKER E. E. Chapman **ADDRESS** Pilot Grove 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*, *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, 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.)

Notes.—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.

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

M. 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. See instructions on back of certificate.

1 PLACE OF DEATH

County Cooper
 Township Pilot Grove 222
 or
 Village _____ 5303
 or
 City _____ (No. _____ St.; _____ Ward)

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of _____ Registered No. _____

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

2 FULL NAME Margret Coffman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX J 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) w

16 DATE OF DEATH Mar 23, 1923
 (Month) (Day) (Year)

6 DATE OF BIRTH _____
 (Month) (Day) (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 _____ m.

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

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

 (Duration) _____ yrs. _____ mos. _____ ds.

9 BIRTHPLACE (State or country) _____

Contributory _____
 (SECONDARY)

10 NAME OF FATHER _____

 (Duration) _____ yrs. _____ mos. _____ ds.

11 BIRTHPLACE OF FATHER (State or country) _____

(Signed) _____, M. D.

12 MAIDEN NAME OF MOTHER Louis Anderson

_____, 191____ (Address) _____

13 BIRTHPLACE OF MOTHER (State or country) Missouri

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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) _____

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(Address) _____

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

15 Filed 3/24 1923 Chas. Kistner REGISTRAR

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

20 UNDERTAKER _____ ADDRESS _____

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