

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 8076

1 PLACE OF DEATH
County Greene
Township Center
or
Village
or
City (NO. St. Ward)

Registration District No. 320 File No.
Primary Registration District No. 5443 Registered No. 8

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

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
6 DATE OF BIRTH February 13 1859
(Month) (Day) (Year)
7 AGE 64 yrs. 0 mos. 24 ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Zanesville Ohio
10 NAME OF FATHER S. N. Alexander
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Zanesville Ohio
12 MAIDEN NAME OF MOTHER Mary M. Carter
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Zanesville Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Boffitt
(Address) Springfield, Mo

15 Filed 3-17 23 W. E. Potter M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH March 9 1923
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from March 5th 1923 to March 9th 1923, that I last saw h. alive on March 9, 1923, and that death occurred, on the date stated above, at 4:30 a. m.
The CAUSE OF DEATH* was as follows:
Thrombosis
109A
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. E. Potter M. D.
March 5, 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.

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 Clear Creek Cem DATE OF BURIAL March 10, 1923
20 UNDERTAKER W. E. Redfern 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), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*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.)

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Greene 320 State MISSOURI Registered No. _____
 Township Center 5443 or Village _____ or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Maggie M. Ramsey
 (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				MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>7</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>W</u>	16 DATE OF DEATH (month, day, and year) <u>Mar 9 - 1923</u>		
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____			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.		
6 DATE OF BIRTH (month, day, and year) _____			The CAUSE OF DEATH* was as follows: <u>Pneumonia</u> <u>bronchial,</u>		
7 AGE Years _____ Months _____ Days _____	If LESS than 1 day, --- hrs. or --- min.	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) _____			
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment (if which employed (or employer) _____ (c) Name of employer _____			CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (city or town) _____ (State or country) _____			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) _____		
PARENTS	10 NAME OF FATHER _____		* 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.)		
	11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____		19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____		
	12 MAIDEN NAME OF MOTHER _____		20 UNDERTAKER _____ ADDRESS _____		
	13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____				
14 Informant _____ (Address) _____					
15 Filed <u>5-24</u> , 19 <u>23</u> <u>Ch. Potter M.D.</u> REGISTRAR					

SUPPLEMENTAL

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TUTION is very important. See instructions on back of certificate.

Exact statement of U.S. Census Bureau.

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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.

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ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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