

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

8534 5/4

1. PLACE OF DEATH  
 County Larayette Registration District No. 1160 File No. \_\_\_\_\_  
 Township Davis Primary Registration District No. 3624-a Registered No. 31  
 City Higginsville (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mrs Martha E. Gray,  
 (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) Widowed,  
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Gray.  
M  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5 1841  
 7. AGE YEARS 81 MONTHS 6 DAYS 21 If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housekeeper  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Cynthiana  
 (STATE OR COUNTRY) Ky.

10. NAME OF FATHER James Gray  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Ky. Cynthiana,  
 12. MAIDEN NAME OF MOTHER Mary Gray  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Penn.

14. INFORMANT James Gray, By Cepha Higginsville Mo  
 (Address) \_\_\_\_\_

15. FILED 3-27 1923 Bessie Porter  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 26 1923  
 17. I HEREBY CERTIFY, That I attended deceased from Monday Mar 19 1923, to Mar 26 1923, that I last saw him alive on Mar 25 1923, and that death occurred, on the date stated above, at 6 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia - (bronch)  
following influenza

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 9 da.  
 CONTRIBUTORY Beside ability -  
 (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH...  HB

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? Physiocal finding thorax  
 (Signed) W. Kappenberg, M. D.  
Mar 29, 1923 (Address) Higginsville, 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 Silent Hill DATE OF BURIAL Mar 28 1923.

20. UNDERTAKER Hoefler & Meinershagen. ADDRESS Higginsville  
 I.O. \_\_\_\_\_

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.

# Standard 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 fullness of various pursuits can be known. The same applies to each and every person, irrespectively of age. For many occupations a single word or phrase on the first line will be sufficient, e. g., *Farmer* or *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. In many cases, especially in industrial employment, it is necessary to know (a) the kind of work done and (b) the nature of the business or industry, therefore an additional line is provided for the statement; it should be used only when needed. Examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Miner*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *sekeepers* who receive a definite salary), may be reported as *Housewife*, *Housework* or *At home*, and men, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If an 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 at death, write *None*.

**Statement of cause of Death.**—Name, first, of the DISEASE CAUSING DEATH (the primary affection in respect to time and causation), using always the accepted term for the same disease. Examples: *Spinal fever* (the only definite synonym is *hemorrhagic cerebrospinal meningitis*); *Diphtheria* (never 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.)

**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.