

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

9709

1. PLACE OF DEATH

County Lawrence Registration District No. 467 File No. _____
 Township _____ Primary Registration District No. 4280 Registered No. 95
 City Aurora (No. _____) St. _____ Ward _____

2. FULL NAME Mrs. Elizabeth A. Martin

(a) Residence, No. 300 West St Louis St. 1st 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

2 MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1845 - Nov 2nd

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 4 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
 (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) Tenn

PARENTS

10. NAME OF FATHER Levi Julian

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER Mary Cunningham

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

14. INFORMANT Levi Martin (Address) Aurora Mo

15. FILED 3-26-23 19.23. Mary D. Melton REGISTRAR

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

17. I HEREBY CERTIFY That I attended deceased from Mar 25 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 12:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
Indefinite (duration) yrs. mos. ds.
 CONTRIBUTORY Hypertension (SECONDARY)
Indefinite (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Microsc
 (Signed) R. D. Cowan M. D.

3-26-1923 (Address) Aurora, 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 DATE OF BURIAL

Maple Park Cemetery Mar 27 1923

20. UNDERTAKER 176-2026 ADDRESS

Maudy King

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) *Spinnner*, (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," "Managor," "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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Lawrence 467 State MISSOURI Registered No. _____
 Township 4280 or Village _____ 25 or
 City Assand No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs Elizabeth A Martin
 (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.

2. min

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>F</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>W</u>		
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____				
6 STATE 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 <u>June 10, 1923</u> <u>Mary D Melton</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH (month, day, and year) <u>Mar 26 1923</u>	
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.	
18 THE CAUSE OF DEATH* was as follows: <u>Myocarditis dx. X</u>	
(duration) <u>90</u> yrs. mos. ds.	
CONTRIBUTORY (SECONDARY) _____ (duration) _____ 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) <u>R. D. Cronan</u> , M. D. <u>6/10, 1923</u> (Address) <u>Aurora Mo.</u>	
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19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20 UNDERTAKER	ADDRESS

SUPPLEMENTAL

11010 is very important. See instructions on back of certificate.

Exact statement of

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