

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

8834

1 PLACE OF DEATH

County Livingston
Township Cream Ridge
OR
Village Chula
OR
City _____ (NO _____ St. _____ Ward _____)

Registration District No. 509 File No. 2
Primary Registration District No. 409 Registered No. 2
567

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

2 FULL NAME Effie May Oldaker

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

16 DATE OF DEATH Mar 2, 1923
(Month) (Day) (Year)

6 DATE OF BIRTH Oct 14, 1896
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 2, 1923 to March 15, 1923 that I last saw her alive on March 15, 1923

7 AGE 26 yrs 4 mos 19 ds. If LESS than 1 day, hrs. or min.?

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

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

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary
234

9 BIRTHPLACE (City or town, State or foreign country) Missouri

(Duration) yrs. mos. ds. 1 1 1

CONTRIBUTORY (Secondary) Alu

(Duration) yrs. mos. ds. 1 1 1

(Signed) O. Proyles M. D.

(Address) _____, 191 _____

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

PARENTS
10 NAME OF FATHER L. H. Griffin
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri
12 MAIDEN NAME OF MOTHER Mollie Baker
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 2 mos. ds. In the 10 yrs. mos. ds. State 10 yrs. mos. ds.

Where was disease contracted if not at place of death? at Chula mo

Former or usual residence _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) L. H. Griffin (Address) Chula mo

19 PLACE OF BURIAL OR REMOVAL Covgill mo DATE OF BURIAL March 5, 1923

15 Filed 32 23 O. Proyles Registrar

20 UNDERTAKER W. Booth ADDRESS Chula 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, 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," "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.)