

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

9881

1 PLACE OF DEATH
County New Madrid
Township West
Village
or City Canalou Mo NO. _____ St. _____ Ward _____

Registration District No. 1133 File No. _____
Primary Registration District No. 4587 Registered No. 1

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

2 FULL NAME Arteliv Vogt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~UNMARRIED~~ WIDOWED Yes
(Write the word)
6 DATE OF BIRTH Dec 8 1899
(Month) (Day) (Year)
7 AGE 42 yrs 3 mos 3 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE
(City or town, State or foreign country) Arroyo Ill

PARENTS
10 NAME OF FATHER Jim Wells
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) State Ky
12 MAIDEN NAME OF MOTHER Mary
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) State Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G R Cathy
(Address) Canalou Mo

15 Filed Apr 6th 1923 Llewellyn Daugherty Registrar

2. MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 7 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 3 1923 to Mar 7 1923, that I last saw her alive on Mar 7 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) _____ yrs. _____ mos. 7 ds.

CONTRIBUTORY (Secondary) Heart failure
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. E. Presnell M. D.
Mar 7 1923 (Address) Canalou

*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 Stanton Mo. DATE OF BURIAL Apr 6 1923

20 UNDERTAKER M. W. ... ADDRESS ...

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*, *Composer*, *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.)

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County New Madrid State MISSOURI Registered No. 1133
 Township _____ or Village 4587 or _____
 City Canalou No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Artelia Volz

(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

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Y

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Oct 8 1858

7 AGE Years 63 Months 03 Days _____
IF LESS THAN 1 day, hrs. or mins.

8 OCCUPATION OF DECEASED

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

9 BIRTHPLACE (city or town) Annie Ill
(State or country)

10 NAME OF FATHER John Wells

11 BIRTHPLACE OF FATHER (city or town) State of Ky
(State or country)

12 MAIDEN NAME OF MOTHER Artelia (Wells)

13 BIRTHPLACE OF MOTHER (city or town) State of Ky
(State or country)

14 Informant J. R. Athey
(Address) Canalou Mo

15 Filed Apr 6 1923 Llewellyn Daugherty REGISTRAR
11-2184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1923

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Heart Failure
pneumonia

(duration) _____ yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Heart Failure

18 Where was disease contracted (duration) _____ yrs. mos. ds.
 if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
 (Signed) W. E. Presnell, M. D.*

_____, 19 (Address) Canalou 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 Sikeston Mo DATE OF BURIAL 2/8 1923

20 UNDERTAKER Marshal-Harrison Munc Co ADDRESS Morhome Mo

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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.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.