

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

Do not use this space.

24020

1. PLACE OF DEATH

County Henry
Township
City Clinton Mo (No.) St. Ward)

Registration District No. 350-352
Primary Registration District No. 5019

File No.
Registered No. 97

2. FULL NAME

Abbie J. Wilson

(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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 17 1923

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF [check]

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1923 to Aug 17 1923 that I last saw her alive on Aug 17 1923, and that death occurred, on the date stated above, at 2:30 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14 1902

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 11 2

Paralysis Quiblety

8. OCCUPATION OF DECEASED

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

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Salisbury (STATE OR COUNTRY) New Hampshire

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH St Clair Co

10. NAME OF FATHER Tom W. Wilson

DID AN OPERATION PRECEDE DEATH? No DATE OF

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Salisbury (STATE OR COUNTRY) New Hampshire

WAS THERE AN AUTOPSY? No

12. MAIDEN NAME OF MOTHER Mandy F. Sawyer

WHAT TEST CONFIRMED DIAGNOSIS Cholera

(Signed) W. J. Stithens, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Salisbury (STATE OR COUNTRY) New Hampshire

8/17/23 Address Clinton 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.)

14. INFORMANT Ellis G. Wilson (Address) Ohio Co, Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Westfield Cemetery DATE OF BURIAL Aug 17 1923

15. FILED 9/8 23 Ed. C. Peeler REGISTRAR

20. UNDERTAKER Spoon Son Clinton Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, 3 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.

DR. N. I. STEBBINS
GEN. SURGEON

MRS. MARIE STRICKLAND
SUPT. OF NURSES

N. I. STEBBINS HOSPITAL

CLINTON, MO. october, 15, 1923.

Missouri State Board of Health,
Bureau of Vital Statistics,
Jefferson City, Mo.

Gentlemen:-

I have before me the death certificate of Abbie J. Wilson, in which I state cause of death was paralysis. Contributory cause senility. Patient was brought to my hospital in a semi-conscious condition; lapsed into un-consciousness which seemed to be associated with a general paralysis she losing the use of her arms and legs as well as other parts of the body, a short time previous to her death. There was no autopsy permitted.

I regret that in my feeble way I am unable to give you further information in regard to the cause of death. Any information you can give me along this line will be appreciated, as it might enable me to diagnose a case of this kind in a more accurate way.

Fraternally,

A handwritten signature in cursive script, reading "N. I. Stebbins". The signature is written in dark ink and is positioned at the bottom right of the page, below the typed name "N. I. Stebbins".

24020

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

24021

1. PLACE OF DEATH

County Henry Registration District No. 350-353 File No.
 Township Primary Registration District No. 3018 Registered No.
 City Clinton (No.) St. Ward (.....)

2. FULL NAME

Albie J. Wilson

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE 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. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 - 19 23

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Analysis Semility

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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(Approved by U. S. Census and American Public Health Association.)

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