

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

8189

**1. PLACE OF DEATH**

County Fremont Registration District No. 508 File No. ....  
Township..... Primary Registration District No. 3024 Registered No. 29  
City Chillicothe (No. ....) St. .... Ward)

**2. FULL NAME**

Mrs Maggie Brown

(a) Residence No. Harris 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar - 5 1924

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF J. L. Brown

17. I HEREBY CERTIFY, That I attended deceased from July 1923, 1923, to Mar 5, 1924 that I last saw her alive on Mar 5, 1924, and that death occurred, on the date stated above, at 7 p. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23rd 1878  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 45- 6 18

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
541P pneumonia (lobar primary)  
139C  
1002 / 101A

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

CONTRIBUTORY (SECONDARY) Anaemia secondary to uterine bleeding (duration) yrs. mos. ds. 6 mos.

9. BIRTHPLACE (CITY OR TOWN) Harris (STATE OR COUNTRY) Mo

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH  
1) Hygiene at home DATE OF Feb 16

10. NAME OF FATHER Hugh Kesterson

WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS? lung signs (Signed) Chillicothe, M. D.

12. MAIDEN NAME OF MOTHER Mary Goodrich

3/6, 1924 (Address) Chillicothe Mo

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

\*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 J. L. Brown (Address) Harris Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Harris Mo DATE OF BURIAL March 7 1924

15. FILED 3-8-24 Reuben Barney REGISTRAR

20. UNDERTAKER F. B. Norman ADDRESS Chillicothe Mo

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.

M  
BTL  
R14  
Br 4  
Occ

# 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 *Nons.*

**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 child-birth 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, OF 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.

requested to make every effort to obtain the information indicated by check marks, lacking from the death certificate:

Name: Mrs Maggie Brown

Who died at: Livingston, Co on Mar 5-1924

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(if nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Place of birth (State or country) \_\_\_\_\_

Place of birth of father (State or country) \_\_\_\_\_

Place of birth of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Pneumonia (Lobar Primary)  
+ Fibroid Uterus with Hemorrhage

Contributory: Anaemia secondary to uterine  
bleeding

Where was disease contracted? \_\_\_\_\_

Did operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Were there any other tests? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

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