

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

Do not use this space.

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**1. PLACE OF DEATH**

County Butter Co. Registration District No. 89  
Township Poplar Bluff Primary Registration District No. 5131  
City R.R. #2 Poplar Bluff Mo. (No. \_\_\_\_\_) (St. \_\_\_\_\_ Ward \_\_\_\_\_)

File No. \_\_\_\_\_  
Registered No. 7 \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Nola Belle Edwards

(a) Residence, No. Doniphan Road St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) near Poplar Bluff Mo. (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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 15 1925

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

17. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_ 1925 to \_\_\_\_\_ 1925 that I last saw her alive on \_\_\_\_\_ 1925 and that death occurred, on the date stated above, at \_\_\_\_\_ 12:30 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) December 28, 1924

THE CAUSE OF DEATH\*\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 18

Flu - 11/13

**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 \_\_\_\_\_

(duration) yrs. mos. da. 17  
CONTRIBUTORY Arteriosclerosis (SECONDARY) (duration) yrs. mos. da. 7

9. BIRTHPLACE (CITY OR TOWN) Doniphan Road (STATE OR COUNTRY) near Poplar Bluff Mo.

18. WHERE WAS DISEASE CONTRACTED Home IF NOT AT PLACE OF DEATH: \_\_\_\_\_

10. NAME OF FATHER German Edwards

DID AN OPERATION PRECEDE DEATH? yes DATE OF 1/17/25

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Nebraska (STATE OR COUNTRY) \_\_\_\_\_

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Mary Blosswood

WHAT TEST CONFIRMED DIAGNOSIS? Cen & Laboratory (Signed) H. F. B. Taylor M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Poplar Bluff Mo. (STATE OR COUNTRY) \_\_\_\_\_

2 - 1, 1925 (Address) Poplar Bluff Mo.

14. INFORMANT German Edwards (Address) R.R. #2 Poplar Bluff 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.)

15. FILED 2/1 1925 W. S. Barley REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Black Creek Cemetery DATE OF BURIAL Jan. 16 1925

20. UNDERTAKER W. W. Gager ADDRESS Poplar Bluff 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, 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 neoplasm); *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.

It is essential that death certificates be made complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Nola Belle Edwards

Died at: Poplar Bluff on Jan 15-1925

Address: No. R. R. # 2 St. Doniphan road  
(If nonresident, city or town)

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

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 father (State or country) \_\_\_\_\_

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

Cause of death: Flue

Contributory: Empyema operation to drain pleural cavity

Bronch's Pneumonia

*110*

How was disease contracted? \_\_\_\_\_

Operation precede death? Yes Date of 1/12/25

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

Name of physician: \_\_\_\_\_

Address of physician: \_\_\_\_\_

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