

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

1925

1. PLACE OF DEATH

County Christian Registration District No. 184 File No. 442-4^B
 Township Grady Primary Registration District No. 0255 Registered No. 2
 City Ozark, Mo. (No. _____) St. _____ Ward _____

2. FULL NAME

Sarah Smith
 (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

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. In Married, Widowed, or Divorced HUSBAND OF (OR) WIFE OF F. M. Smith

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>64</u>	<u>7</u>	<u>11</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Rhodes</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>France</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Jensenberg</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>France</u> (STATE OR COUNTRY)

14. INFORMANT Marion Smith
 (Address) Ozark, Mo.

15. FILED McH. 28 1925 Louella Leonard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 1925
 17. I HEREBY CERTIFY, That I attended deceased from Dec 31st 1924 to Jan 6 1925
 that I last saw her alive on Jan 6 1925, and that death occurred, on the date stated above, at 10 h. a.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
 (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. H. Wade M. D.
Jan 7 1925 (Address) Ozark 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 Ozark Cemetery DATE OF BURIAL Jan 9 1925

20. UNDERTAKER T. B. Cheffin ADDRESS Ozark 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.

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," "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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

442 ^B/₁

1. PLACE OF DEATH

County Christian Registration District No. 184 File No. _____
Township Frank Primary Registration District No. 5255 Registered No. 1
City Ozark Mo. (No. _____) St. _____ Ward _____

2. FULL NAME

Sarah Smith
(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF wife of Marion Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 25 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>64</u>	<u>7</u>	<u>11</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(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) Missouri

10. NAME OF FATHER Rhodes

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

12. MAIDEN NAME OF MOTHER Inenberger

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

14. INFORMANT Marion Smith
(Address) Ozark Mo.

15. FILED Apr 4 1925 L. L. Latta Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 6 1925

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Jan 6, 1925— that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 10:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

10/10 (duration) _____ mos. 8 da.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
Jan 10 (Signed) J. H. Wade _____ M. D.
1925 (Address) Ozark 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 Ozark Cemetery DATE OF BURIAL Jan. 8 1925

20. URBERTAKER T. B. Chaffin ADDRESS Ozark Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

<p>1. PLACE OF DEATH</p> County..... Township..... City..... (No. St. Ward)	<p>Registration District No. File No. Primary Registration District No. Registered No.</p>	
<p>2. FULL NAME</p>		
<p>(a) Residence, No. St. (Usual place of abode)</p>	<p>Word. (If nonresident give city or town and State)</p>	<p>da. How long in U.S., if of foreign birth? yrs. mos. da.</p>
<p>PERSONAL AND STATISTICAL PARTICULARS</p>		
<p>3. SEX</p>	<p>4. COLOR OR RACE</p>	<p>5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)</p>
<p>5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF</p>		
<p>6. DATE OF BIRTH (MONTH, DAY AND YEAR)</p>	<p>7. AGE YEARS MONTHS DAYS</p>	<p>IF LESS than 1 day, hrs. or min.</p>
<p>8. OCCUPATION OF DECEASED</p> <p>(a) Trade, profession, or particular kind of work</p> <p>(b) General nature of industry, business, or establishment in which employed (or employer)</p> <p>(c) Name of employer</p>		
<p>9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)</p>		
<p>10. NAME OF FATHER</p>		
<p>11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)</p>		
<p>12. MAIDEN NAME OF MOTHER</p>		
<p>13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)</p>		
<p>14. INFORMANT</p>		
<p>15. FILED..... 19.....</p>		
<p>16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....</p>		<p>17. I HEREBY CERTIFY, That I attended deceased from that I last saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....</p> <p style="text-align: center;">THE CAUSE OF DEATH* WAS AS FOLLOWS:</p> <p>.....</p> <p>..... (duration)..... yrs. mos. da.</p> <p>..... (duration)..... yrs. mos. da.</p>
<p>MEDICAL CERTIFICATE OF DEATH</p>		
<p>18. WHERE WAS DISEASE CONTRACTED</p> <p>IF NOT AT PLACE OF DEATH..... DATE OF.....</p> <p>DID AN OPERATION PRECEDE DEATH..... DATE OF.....</p> <p>WAS THERE AN AUTOPSY.....</p> <p>WHAT TEST CONFIRMED DIAGNOSIS.....</p> <p>(Signed)....., M. D.</p> <p>....., 19..... (Address)</p>		<p>19. PLACE OF BURIAL, CREMATION, OR REMOVAL</p> <p>DATE OF BURIAL 19.....</p>
<p>*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.)</p>		<p>20. UNDERTAKER</p> <p>ADDRESS</p>

PARENTS

REGISTRAR

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Christian
Township Zimley
City (No.) St. Ward)

Registration District No. 184
Primary Registration District No. 5-253-

File No.
Registered No. 2
St. Ward)

2. FULL NAME

Sarah Smith

(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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 14 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 7 11

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 Feb. 1, 1928 Louella Leonard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 19 23

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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)

*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.

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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

442B