

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

1434^e

1. PLACE OF DEATH

County GasconadeRegistration District No. 448

File No. _____

Township _____

Primary Registration District No. 5608

Registered No. _____

City Conway (No. _____) St. _____

Ward _____

2. FULL NAME Frances Shockley

(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 82 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Goosh Shockley6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 - 1843

7. AGE

YEARS 82

MONTHS _____

DAYS _____

IF LESS than 1 day, _____ hrs. or _____ min.

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) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____

(STATE OR COUNTRY) Probate Co. Mo.10. NAME OF FATHER Sam Hending

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____

(STATE OR COUNTRY) Ills.12. MAIDEN NAME OF MOTHER Durbina

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____

(STATE OR COUNTRY) _____

14.

INFORMANT Bud Hending
(Address) _____

15.

FILED Mar 10 1927N. B. Clinton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 192717. I HEREBY CERTIFY, That I attended deceased from 1-2-27, 1927 to 1-7, 1927 that I last saw him alive on 1-7, 1927, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of neck of 1861
Fracture of the 1861
injury
(duration) _____ yrs. _____ mos. _____ da.

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) J. M. Pridemore, M. D., 19 27 (Address) Conway

*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 ConwayDATE OF BURIAL Jan 8 192720. UNDERTAKER no

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 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, 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.

**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 Boone Registration District No. 448 File No.
 Township Primary Registration District No. 5608 Registered No.
 City Conway (No.) St. Ward)

2. FULL NAME

(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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Wid
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 - 1843
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 | 2 | 1 | | |

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 May 19 27 N. B. Benton
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1926
 17. I HEREBY CERTIFY That I attended deceased from
 to 19....., 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:

Fracture of neck of femur from fall
 (duration) yrs. mos. da. *

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)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

PARENTS

WITNESSES

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15

SUPPLEMENTARY

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