

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

8507

1. PLACE OF DEATH

County Lewis Registration District No. 478 File No. _____
 Township Highland Primary Registration District No. 5642 Registered No. 7
 City Shurham (No. _____) St. _____ (Ward _____)

2. FULL NAME

Talitha J Shires

(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 10 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 25 1925

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

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1925, to Mar 25 1925, that I last saw her alive on Mar 25 1925, and that death occurred, on the date stated above, at 6:00 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 18 1888

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 67 2 8

Heart Failure
75 hrs

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

(duration) 1/2 hour
 CONTRIBUTORY Not Known
 (SECONDARY) (duration) _____

9. BIRTHPLACE (CITY OR TOWN) Shurham
 (STATE OR COUNTRY) Lewis Co Mo

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

10. NAME OF FATHER J R Raines

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Lewis Co Mo

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Oliver Hampton

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W H Custer, M. D.
 , 19 (Address) Shurham Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Lewis Co 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 B C Shires
 (Address) Quincy Ill.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ball & Ball
 DATE OF BURIAL Mar 27 1925

15. FILED 2/2 19 25 Adna K. Ball
 REGISTRAR

20. UNDERTAKER Ball & Ball
 ADDRESS Cewing.

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 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.

This Subject.

Mrs. Talitha J. Shires had not had
an attending Physician for several
years. Death occurred about 5 Min. before
I came in the house. There was
nothing to justify an Inquest or an
Autopsy. The history I obtained justifies
me in saying that she died from failure
of the heart, but can not state that disease
existed, or where the rupture occurred

Yours Truly
Wm. Custer M.D.

E. C. Rohrbach, M. D., Flat River
H. H. Helbing, M. D., St. Louis
Geo. Tracewell, M. D., Edwardsville, Ill.

CENSORIAL—

B. J. Wiesner, M. D., St. Louis
E. H. Zenor, M. D., St. Louis
A. W. Davidson, M. D., Poplar Bluff

PRESS—

A. H. Koch, M. D., St. Louis
G. W. Tremaine, M. D., St. Louis
C. H. Riggs, M. D., Middletown

ETHICS—

J. L. Harwell, M. D., Poplar Bluff
C. W. Nehl, M. D., St. Louis
E. R. Waterhouse, M. D., St. Louis

LEGISLATIVE—

J. A. Son, M. D., Bonne Terre
J. R. Barry, M. D., Cartersville
E. E. Jones, M. D., Lilbourne

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W. P. Birney, M. D., Hannibal
C. E. Feller, M. D., Springfield
C. S. Glover, M. D., Russellville
Ida Kittridge, M. D., St. Louis
F. M. Nufer, M. D., St. Louis
W. A. Stearns, M. D., Savannah
W. J. James, M. D., Excelsior
S. M. McCubbin, M. D., Kansas City

S. F. Freeman, M. D., Springfield
W. P. Duckworth, M. D., Calendonía
D. S. Talbott, M. D., Appleton City
G. D. Harris, M. D., Jamesport
J. E. Cave, M. D., Kansas City
A. E. Snow, M. D., St. Louis
W. E. Barry, M. D., Cartersville
W. H. Goad, M. D. Berine

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Joseph Gill, M. D., Secretary, St. Louis

PRACTICE OF MEDICINE—

A. F. Stephens, M. D., Chairman, St. Louis
C. E. Feller, M. D., Secretary, Springfield

MISCELLANEOUS

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 City _____ (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

Salitha J. Shiras

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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) Jan 18-1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
67 2 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
 (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) Mar 26-1925

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Heart Failure

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
2050W

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 _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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