

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

Do not use this space.

29034

1. PLACE OF DEATH

County Shelby
Township Clara
City Clarence (No.)

Registration District No. 899 Hall
Primary Registration District No. 4500

File No.
Registered No. 27
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

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 John Wesley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 10 - 1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 7 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Honorary wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Carlton Smith

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

12. MAIDEN NAME OF MOTHER Mollie Turner

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

14. INFORMANT Miss Lutie Smith (Address) Clarence

15. FILED 10/27/25 Ray Hamilton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30 1925

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1925, to Sept 30 1925 that I last saw her alive on Sept 30 1925, and that death occurred, on the date stated above, at 4 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Emboli following Pan. Hypostomy

CONTRIBUTORY (SECONDARY) Fibroid & Cystic Lesion (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? L

DID AN OPERATION PRECEDE DEATH? no DATE OF Sept 25

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? L

(Signed) J. M. Hall M. D. (Address) Clarence 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 Union Cemetery DATE OF BURIAL Oct 2 1925

20. UNDERTAKER E. E. Hopper ADDRESS Clarence

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.

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

1. PLACE OF DEATH.

County Shelby Registration District No. 827 File No. _____
 Township _____ Primary Registration District No. 4500 Registered No. 22
 City Clarence (No. _____) St. _____ Ward _____

2. FULL NAME

Frances Wesley
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 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.
 (If nonresident give city or town and State)

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) _____

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

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 1 of 2 1925 Roy Hamilton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30 19 25

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:
Cerebral emboli following
panhypotension

CONTRIBUTORY (SECONDARY) fibroid & cystic tumor (duration) yrs. mos. ds.
non malignant (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 7413
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) A. M. Hall, M. D.
 , 19 (Address) Clarence Mo

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

20. UNDERTAKER ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

THIS IS A PERFECT COPY OF THE ORIGINAL RECORD
 N. B.—Every item of information on this form should be properly classified and be a part of the cause of death in plain terms.

Fees shall not receive a fee for certificates unless they are complete as prescribed by law.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health
Association.)

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2003