

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

Do not use this space.

29091

1. PLACE OF DEATH

County Texas
Township Piner
City No.

Registration District No. 2631
Primary Registration District No. No.

File No. No.
Registered No. 14
St. No. Ward No.

2. FULL NAME

Salah E. Inoues

(a) Residence. No. No. St. No. Ward No.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-4 1925

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

17. I HEREBY CERTIFY, That I attended deceased from without doctor, 1925, and that I last saw h. alive on, 1925, and that death occurred, on the date stated above, at No. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1949

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Supposed Paralysis

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (SECONDARY) No
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) No.
(STATE OR COUNTRY)

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

10. NAME OF FATHER Wesley Forester

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

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

WAS THERE AN AUTOPSY?.....

12. MAIDEN NAME OF MOTHER Unknown

WHAT TEST CONFIRMED DIAGNOSIS?.....

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

(Signed) No., M. D.
, 19 (Address)

14. INFORMANT John Barry
(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.)

15. FILED 9-4-25 J. J. McDonald
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Emerg. cemetery DATE OF BURIAL 8-5-25

20. UNDERTAKER H. V. Elliott ADDRESS Worship

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, 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 "Asthma," "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 septi emia," "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 Texas Registration District No. 863 File No. _____
 Township Priney Primary Registration District No. _____ Registered No. 14
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Sarah E. Groves

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 4 1925

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

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.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suppurated Paralysis of the Larynx
 (duration) yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) 74
 (duration) yrs. mos. ds.

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 _____

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

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

10. NAME OF FATHER _____

WAS THERE AN AUTOPSY? _____

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

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. F. Barney, M. D.
 (Address) Houston, Tex.

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) _____

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

15. FILED 8-5-25 1925 J. R. M... UNDERTAKER _____ REGISTERAR _____ ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT ... CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. CAUSE OF DEATH ... PHYSICIANS ... EXACT STATEMENT OF OCCUPATION IS ...

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

BRONCH

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