

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

1927

PLACE OF DEATH

County McDonald
Township Boyer
City Goodman Mo (No.)

Registration District No. 142
Primary Registration District No. 5693

File No. V 30528 B
Registered No. St. Ward

2. FULL NAME

Agness Chancellor

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9 - 1915

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1
				day, hrs. or min.
	10	4	19	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Goodman Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER James Chancellor

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Benton Co Ark.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Jessie Rogers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Newton Co Mo
(STATE OR COUNTRY)

14. INFORMANT Jessie Chancellor
(Address) Goodman Mo.

15. FILED 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 28 19 25

17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1925, to Oct 28, 1925, that I last saw her alive on Oct 28, 1925, and that death occurred, on the date stated above, at 11 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid

CONTRIBUTORY (SECONDARY)

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

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. J. Rogers M. D.
, 19 (Address) Goodman 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 Oak wood Cemetery DATE OF BURIAL 10 29 1925

20. UNDERTAKER Chas W. Williams 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," "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
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Mo Donald Registration District No. 142 File No.
 Township Crane Primary Registration District No. 3692 Registered No.
 City Crane (No. 22) St. Ward)

2. FULL NAME Agness Chancellor
 (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) Single
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9 - 1915
 7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min. 10 | 4 | 19
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Schoolgirl
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Goodman, Mo
 10. NAME OF FATHER James Chancellor
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Beaumont Co, Ark
 12. MAIDEN NAME OF MOTHER Jessie Rogers
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Newton Co, Mo

14. INFORMANT NAME Jessie Chancellor
 (Address) Goodman, Mo
 15. FILE NO. 27 REGISTRAR Chas. St. Williams

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 28 1935
 17. DECEASED CERTIFIED That I attended deceased from Sept 24 to Oct 28, 1935
 that I last saw him alive on Oct 28, 1935, and that death occurred, on the date stated above.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Asphyxiation
 (description) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (description) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST DETERMINED DIAGNOSIS?
St. W. F. Franzer, M. D.
 , 19 (Address) Goodman, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE 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 Oakwood Cemetery DATE OF BURIAL 10/29 1935
 20. UNDERTAKER Chas. St. Williams ADDRESS Goodman, Mo

TEMPORARILY FILED

5-225-8