

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

33915

1. PLACE OF DEATHCounty St. JamesTownship St. JamesCity St. JamesRegistration District No. 678Primary Registration District No. 5904File No. 52

Registered 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Miss A. Burton</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 6th 1900</u>		
7. AGE <u>25</u>	YEARS <u>8</u>	MONTHS <u>20</u>
IF LESS than 1 day, _____ hrs. or _____ min.		

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work House wife
- (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 Missie Clark(Address) 2611 Madison St St Louis**15.**

FILED _____

19 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 26th 192517. I HEREBY CERTIFY That the deceased was born Mar 6th 1900 at St. James, Mo. and that I last saw her live on Nov 15th 1925, and that death occurred, on the date stated above, at 3:15 a. m.**THE CAUSE OF DEATH* WAS AS FOLLOWS:**Pericardial Tamponade & Exhaustion.**CONTRIBUTORY (SECONDARY)****18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? NoWAS THERE AN AUTOPSY? No**WHAT TEST CONFIRMED DIAGNOSIS?**(Signed) J. B. Henderson M. D.
11/25/25 (Address) St. James Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSE, 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**Manassas Cemetery11/28 1925**20. UNDERTAKER****ADDRESS**James and Thos EgleSt. James Mo

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, 8 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 neoplasma); *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.

Duplicate

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

Do not use this space.

1. PLACE OF DEATH

County Phelps Registration District No. 678 File No. 512
 Township St. James Primary Registration District No. 5904 Registered No. _____
 City St. James (Name) _____ St. _____ Ward _____

2. FULL NAME

Ladie Ann Britton
 (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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
(write the word)

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

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

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
<u>25</u>	<u>8</u>	<u>20</u>		

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)
St. James, Phelps, Mo.

10. NAME OF FATHER Charles L. Cox

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
St. James, Mo.

12. MAIDEN NAME OF MOTHER Sarah Chilton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)
St. James, Mo.

14. INFORMANT (Address)
Minnie Clark

15. FILED 11-30-25 Alice L. Mendt
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-26 1925

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1925, to Nov. 26, 1925, that I last saw h. or alive on Nov., 1925, and that death occurred, on the date stated above, at 3:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pernicious vomiting and exhaustion

CONTRIBUTORY (SECONDARY) Pregnancy

18. WHERE WAS DISEASE CONTACTED 14302
 IF BY A _____ OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. B. Underwood, M. D.

(Address) St. James, Mo.

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL Masonic Cemetery **DATE OF BURIAL** 11-28 1925

20. UNDERTAKER Jonas L. Fox Eye **ADDRESS** St. James, Mo.

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 OCCUPATIONS is very important.

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