

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

Do not use this space.

3688

1. PLACE OF DEATH
 County Boonville Registration District No. 1057
 Township Green Primary Registration District No. 6214
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Melvin A. Deen
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 43 yrs. 9 mos. 6 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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 21, 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
43 9 6

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Deen's 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) Boonville Mo.

10. NAME OF FATHER Joseph Deen

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

12. MAIDEN NAME OF MOTHER Fanny Melkerson

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

14. INFORMANT (Address) Joseph Deen
Marta Mo.

15. FILED Jan 27 1926 REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26, 1926

17. I HEREBY CERTIFY That I attended deceased from July 7, 1925 to Jan 26, 1926 that I last saw her alive on Jan 26, 1926, and that death occurred, on the date stated above, at 12:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary of Thromb

46 (duration) yrs. 7 mos. 0 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) 0 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH at place of death
 DID AN OPERATION PRECEDE DEATH? No DATE OF None
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? None
 (Signed) C. A. McLean, M. D.
Jan 27, 1926 (Address) Boonville Mo.

*State the DISEASE CAUSING DEATH, or in death 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 Snider Cemetery DATE OF BURIAL 1-28-26

20. UNDERTAKER H. Anderson ADDRESS Boonville 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 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 "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 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
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Hart Registration District No. 1057 File No. 21
 Township Green Primary Registration District No. 6214 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Nellie W. Deen
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 4 1/2 yrs. 9 mos. 5 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1926
 17. I HEREBY CERTIFY That I attended deceased from July 19 1925 to Jan 26 1926 that I last saw her alive on Jan 26 1926 and that death occurred, on the date stated above at 12:45 m.

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Obsolescence of uterus

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 21 - 1883
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 9 5

CONTRIBUTORY (SECONDARY) 46 (duration) 0 yrs. 0 mos. 0 ds.

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 _____

18. WHERE WAS DISEASE CONTRAILED IF NOT AT PLACE OF DEATH Place of death
 DID AN OPERATION PRECEDE DEATH? no DATE none
 WAS THERE AN AUTOPSY? no

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adrian, Mo.

WHAT TEST CONFIRMED DIAGNOSIS? none
 (Sign) O. W. Gilmanson, M.D.
 (Address) Genry, Mo

10. NAME OF FATHER Joseph Albert

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no

12. MAIDEN NAME OF MOTHER Miss Wilkerson

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

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14. INFORMANT Joseph W. Deen
 (Address) Hart, Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Wilder Cemetery 1-28 1926

15. FILED Feb 10 1926 R. O. Meek REGISTRAR
March

20. UNDERTAKER ADDRESS
E. Andries Worth, Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS SHOULD STATE

TEMPORARILY CLOSED

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