

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

FEB 31 1926

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

V 5041

1. PLACE OF DEATH

County Jasper Registration District No. 417 File No. \_\_\_\_\_  
Township \_\_\_\_\_ Primary Registration District No. 2021 Registered No. 23  
City Webb City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Mrs. Elizabeth Kear  
(a) Residence No. 823 W. First 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 (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 25, 1835  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
90 | 3 | 10  
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) Webb City  
(STATE OR COUNTRY) Ill.

10. NAME OF FATHER Labon

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

12. MAIDEN NAME OF MOTHER Adams

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

14. INFORMANT A. J. Kear  
(Address) Webb City, Mo.

15. FILED 75 19 26 A. M. Stormont  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1926

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_  
Jan 26, 19 26 Feb 4, 19 26  
that I last saw him alive on Feb 4, 19 26 and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hypostatic Pneumonia  
1476  
97 (duration) yrs. mos. ds. 4  
CONTRIBUTORY (SECONDARY) Atherosclerosis  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) R. M. Stormont M. D.  
75, 19 26 (Address) Webb City, 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 Castertown Cem DATE OF BURIAL 2/6 1926

20. UNDERTAKER Webb City Und C ADDRESS Webb City

WRITE PLAIN INK—THIS IS A PERMANENT RECORD

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.

# LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

### 1. PLACE OF DEATH

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No.....  
 City..... (No.....) 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.

### PERSONAL AND STATISTICAL PARTICULARS

3. SEX  
 4. COLOR OR RACE  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (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..... 19..... REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....  
 17. I HEREBY CERTIFY, That I attended deceased from that I last saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. ds.  
 18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH..... DATE OF.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY.....  
 WHAT TEST CONFIRMED DIAGNOSIS..... (Signed)....., M. D.  
 , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from UNKNOWN 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 DATE OF BURIAL  
 20. UNDERTAKER ADDRESS

PARENTS

STATE MISSOURI REGISTRAR'S REPORT

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.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Jasper  
Township \_\_\_\_\_  
City \_\_\_\_\_

Registration District No. 417  
Primary Registration District No. 3021

File No. \_\_\_\_\_  
Registered No. 23  
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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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 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) \_\_\_\_\_

PARENTS

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 4/16/16 RW Stomont  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 4 1916

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia  
bronchial  
CONTRIBUTORY (SECONDARY) ood  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

SUPPLEMENTARY

# 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

5-504  
"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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.