

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

Do not use this space.

6919

1. PLACE OF DEATH

County Stone Registration District No. 1096
Township Flat Creek Primary Registration District No. 6347
City Cape Fair (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Mahala C. Richardson

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 28, 1926

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 70 0 0 0 0

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) Missouri

10. NAME OF FATHER Mathias Reed

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

12. MAIDEN NAME OF MOTHER Reed

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

14. INFORMANT W. A. Carr
(Address)

15. FILED _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-7-1926

17. I HEREBY CERTIFY, That I attended deceased from July, 1925, to 2-7, 1926 that last seen alive on about 2-1, 1926, and that death occurred, on the date stated above, at 5:45 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General debility, ~~and~~ uremic poisoning

CONTRIBUTORY Em. debility (SECONDARY) (duration) 2 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?.....

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. P. Doyt, M. D. #17, 1926 (Address) Cape Fair 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 Cape Fair, Mo DATE OF BURIAL 2-8-1926

20. UNDERTAKER W. A. ADDRESS

N.B.—Every item of information should be carefully checked. 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, 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 STATEMENT
BY PHYSICIAN.

**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 Stone Registration District No. 1896 File No. _____
 Township Flat Creek Primary Registration District No. 6247 Registered No. 1
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

Mahala C. Richardson
 (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 A. 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) Oct. 28

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 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) Mo.

PARENTS

10. NAME OF FATHER Mathias Reed
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Iowa
 12. MAIDEN NAME OF MOTHER Wood
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Iowa

14. INFORMANT H. A. Carr
 (Address) Cape Fair, Mo.

15. FILED May 15, 26 Chas. H. Barney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 7 19 26

17. I HEREBY CERTIFY That I attended deceased from _____ 19 _____ that I last saw him _____ alive on _____ 19 _____ and that death occurred, on the date herein above, at _____ 3:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General debility
Neurotic poisoning
Heart failure
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) General debility
 (duration) 2 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: 129 B

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED DIAGNOSIS: _____ (Signed) J. C. B. Loggett, M. D. 4/17/26 (Address) Cape Fair, Mo.

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cape Fair, Mo. DATE OF BURIAL 2-8 19 26

20. UNDERTAKER H. D. ADDRESS _____

MISSOURI STATE BOARD OF HEALTH

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

PRINTED IN PLAIN TERMS, SO THAT IT IS FULLY UNDERSTOOD BY ALL.

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BY PHYSICIAN.

5-6919