

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

Do not use this space.

12950

MAY 26 1926

1. PLACE OF DEATH

County Jasper
Township West Pt.
City West Pt.

Registration District No. 417
Primary Registration District No. 3021

File No. _____
Registered No. 66
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 910 N. 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) Married
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 23, 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
22 6 22

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)
Okemugee Oklahoma

10. NAME OF FATHER William Norman

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

12. MAIDEN NAME OF MOTHER Maudie Wheeler

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

14. INFORMANT (Address) Arthur Campbell West City, Mo.

15. FILED 4-16-1926 A. W. Stormont REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14, 1926

17. I HEREBY CERTIFY That I attended deceased from April 6, 1926, to April 19, 1926 that I last saw him alive on April 14, 1926, and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia (infectious) from blue specks

CONTRIBUTORY (SECONDARY) Influenza (duration) _____ yrs. _____ mos. 8 ds.
10 (duration) _____ yrs. _____ mos. 20 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) M. S. Wright M.D.

*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 DATE OF BURIAL

Wm. Hope Green 4/16 1926

20. UNDERTAKER

ADDRESS

Wm. S. Christal West City, 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.

THIS IS A PERMANENT RECORD

United States Standard Certificate of Death

U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative importance of various pursuits can be known. The certificate applies to each and every person, irrespec-

For many occupations a single word or phrase on the first line will be sufficient, e. g., *Farmer or Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. In many cases, especially in industrial occupations, it is necessary to know (a) the kind of occupation and (b) the nature of the business or industry. Therefore an additional line is provided for a more precise statement; it should be used only when necessary. Examples: (a) *Spinner*, (b) *Cotton mill*, (c) *Foreman*, (d) *Auto-ry*. The material worked on may form the second statement. Never return "Foreman," "Manager," "Dealer," etc., for a more precise specification, as *Day laborer, Miner, Laborer—Coal mine*, etc. Women at home are engaged in the duties of the household (not paid *Housekeepers* who receive a salary), may be entered as *Housewife*, 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 *Cook, Housemaid*, etc. If the occupation has changed or given up on account of the illness, state occupation at beginning of illness. If retired from business, that should be indicated thus: *Farmer (retired, 6 years)*, persons who have no occupation what-

Statement of Cause of Death.—Name, first, the primary affection (the primary affection with time and causation), using always the standard term for the same disease. Examples: *Typhoid fever* (the only definite synonym is *cerebrospinal meningitis*); *Diphtheria* (never report "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.