

AGE should be carefully supplied. AGE should be stated in full 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

32544

1. PLACE OF DEATH

County Pulaski
Township Union
City Union

Registration District No. 711
Primary Registration District No. 14479

File No. 14
Registered No. 22
St. _____ Ward _____

2. FULL NAME

Agnes Lorraine Montague
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) ✓

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/30 1926

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. ✓ ✓ ✓ 1 hrs.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(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 Leonard J. Montague

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

12. MAIDEN NAME OF MOTHER Vivian Hull

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

14. INFORMANT Leonora J. Montague

(Address) Dixon Mo

15. FILED 10-21-28 M. F. Palmer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 20 1928

17. I HEREBY CERTIFY, That I attended deceased from Home, Road _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Circulation in cond cut off
160 B

CONTRIBUTORY (SECONDARY)

160 B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

18. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

18. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) A. J. Briner, M. D.

, 19____ (Address) Dixon 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

12
Uniontown

DATE OF BURIAL

10/21 1928

20. UNDERTAKER

F. H. Gilbert

ADDRESS

Dixon 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, Compositor, 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.; *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.

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 Pulaski Registration District No. 711 File No. 32544
Township Union Primary Registration District No. 5940 Registered No. _____
City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME Agnes Lorraine Montague
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX H 4. COLOR OR RACE A 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(Specify the word)

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 20 1926

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ (that I last saw him alive on _____, 19____, and that death occurred, on the date stated above) at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

circulation in cord cut off

18. (duration) yrs. mos. ds.
16 10 3
19. (duration) yrs. mos. ds.

WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

20. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

21. WAS THERE AN AUTOPSY? _____

22. WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
, 19 (Address)

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or FATAL. (See reverse side for additional space.)

23. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

24. UNDERTAKER _____ ADDRESS _____

INFORMANT (Address) _____

15. FILED 10 21 1926 noted
REGISTRAR

Was this a still-birth? The original certificate states that the child lived one hour and also states that the child was born dead. Please correct the conflicting statements. - Thanks -

Born alive, lived 1 hour

Every item on this form should be carefully supplied. AGE should be stated in full years, months and days. SEX should be stated in full terms. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.