

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

PLACE OF DEATH
County Douglas
Township Litchfield
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1075 File No. 34402
Primary Registration District No. 5381 Registered No. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Norma Nadine Burkes

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>9</u> <u>23</u> <u>1926</u> (Month) (Day) (Year)		
AGE <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. IF LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Babe</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Seymour Mo</u>		
PARENTS	NAME OF FATHER <u>J. F. Burkes</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
	MAIDEN NAME OF MOTHER <u>Laura Eva Robinson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laura Eva Burkes
(ADDRESS) Seymour, Mo R5
Filed 11/23 1926 J. E. Hale
REGISTRAR

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>11</u> <u>22</u> <u>1926</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at <u>6:30 a</u> a.m.	
The CAUSE OF DEATH* was as follows: <u>Had no physician</u> <u>Suppose it was influenza</u>	
(Duration) _____ yrs. _____ mos. _____ ds.	
Contributory (SECONDARY) <u>11 B</u> (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) _____ M. D.	
_____, 191____ (Address)	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
Where was disease contracted if not at place of death? _____	
Former or usual residence _____	
PLACE OF BURIAL OR REMOVAL <u>Osprey Cemetery</u>	DATE OF BURIAL <u>11/23</u> <u>1926</u>
UNDERTAKER <u>Neighfous</u>	ADDRESS _____

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, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)

**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 Douglas

Township Lincoln

City Norma

Registration District No. 1075

Primary Registration District No. 5381

File No. 6

Registered No. 6

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. ...

ds. ...

How long in U.S., if of foreign birth?

Yrs. ...

mos. ...

ds. ...

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) D

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 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 2/21/27

J E Hale

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 22 19 26

17.

I HEREBY CERTIFY, That I attended deceased from ... to ..., 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:

Admitted physician
supposed it was
phlebotomy
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) ...

(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? ...

WHAT TEST CONFIRMED DIAGNOSIS? ...

(Signed) J E Watson, M. D.

7/26, 1927 (Address) ...

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER 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

19

20. UNDERTAKER

ADDRESS

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 recorded. Exact statement of OCCUPATION is very important.

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