

DEC 22 1926

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DEPARTMENT OF VITAL STATISTICS
STATE OF IOWA

ORIGINAL

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH
 County Hodaway State Mo. Registered No. 21
 Township Hopkins or Village _____
 City Hopkins No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Nancy Jane Noles
 (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 6 yrs. 0 mos. 0 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 John Noles
 6 DATE OF BIRTH (month, day, and year) June 9, 1840
 7 AGE Years 86 Months 5 Days 1
 If less than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housekeep̄r
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9 BIRTHPLACE (city or town) Charlestown
 (State or country) Ill.

10 NAME OF FATHER Ulent Thistle

11 BIRTHPLACE OF FATHER (city or town) _____
 (State or country) Ind.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
 (State or Country) Unknown

14 Informant Dr. Sargent
 (Address) Hopkins, Mo.

15 Filed 11/22, 1926 by O. H. Dayler
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1926

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 1926 to Nov 10 1926
 that I last saw her alive on Nov 1 1926
 and that death occurred, on the date stated above, at 2:15 P.m.
 THE CAUSE OF DEATH* was as follows:

Anemia
186A
11/24/26
716
 (duration) 2 yrs. _____ mos. _____ ds.
 CONTRIBUTORY fracture of hip, intracapsular
 (Secondary) (duration) yrs. _____ mos. _____ ds.

18 Where was disease contracted
 if not at place of death? in house at home
 Did an operation precede death? no Date of _____

Was there an autopsy? no
 What test confirmed diagnosis? physical examinations
 (Signed) D. A. Sargent, M. D.
 , 19 (Address) Hopkins 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 Watson, mo. DATE OF BURIAL Nov 19 1926

20 UNDERTAKER A. L. Stithum ADDRESS Burford Iowa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

V. S. NO. 1—ORIGINAL

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 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaus-

tion," "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.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

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

ALL INFORMATION COLLECTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Madison Registration District No. 624 File No. 21
 Township Stephens Primary Registration District No. 4875 Registered No. _____
 City (No.) _____ St. _____ Ward _____

2. FULL NAME Nancy Jane Roles
 (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 wid
(write the word)

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 _____

19 _____

1/3 No. O.H. Sawyer
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 19 76

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 _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Asphyxia
 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Fracture of hip
metacarpals _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHETHER DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
slipped off edge of bed,
and struck on floor.
 DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____

, 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 _____

19 _____

20. UNDERTAKER _____

ADDRESS _____

WRITE ONLY, WITH UNFADING 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.

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

SUPPLEMENTARY