

DEC 22 1926

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

Do not use this space.

37070

1. PLACE OF DEATH

County *Washington*  
Township *Brinsford*  
City *Brinsford*

Registration District No. *976*  
Primary Registration District No. *6187*

File No. *11*  
Registered No. *11*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Elizabeth Pecor*

(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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *W*

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. *About 60*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *House keeper* (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) *Old Mines Mo.* (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER *Frank Pecor*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Old Mines Missouri* (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER *Pauline Cordia*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Paris France* (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT *Andrew Bourbon* (Address) *Corsica Mo.*

15. FILED *Dec 21, 1926* *Chas. Martin* 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 *Nov 7*, 19*26*, to *Nov 10*, 19*26* that I last saw h. \_\_\_\_\_ alive on *Nov 7*, 19*26*, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Paralysis. Cause not definitely known* (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) *820* (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. *At place of death*

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *A. P. Mincey*, M. D. , 19 (Address) *Bliss 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 *Aickwoods* DATE OF BURIAL *Nov 11 1926*

20. UNDERTAKER *[Signature]* ADDRESS *Aickwoods 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

# 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 STATEMENTS  
BY PHYSICIAN.

STATE BOARD OF HEALTH  
 DEPARTMENT OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

PLACE OF DEATH  
 County Wash. Registration District No. 976 File No. 11  
 Township Sumner Primary Registration District No. 6187 Registered No. 11  
 City Elizabeth (No. 1) St. Elizabeth (Ward 1)

2. FULL NAME Elizabeth Riccar  
 (a) Residence. No. 1 St. Elizabeth Ward 1  
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. about 72  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work House Keeper  
 (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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 1976  
 17. I HEREBY CERTIFY That I attended deceased from 1976 to 1976, and that I last saw him alive on May 7, 1976, and that death occurred, on the date stated above, at Unknown m.  
 THE CAUSE OF DEATH WAS AS FOLLOWS:  
Paralysis caused not definitely known  
 (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) 75B  
 (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) A.P. M. Esq., M. D.  
 , 19 (Address) Bliss Lane  
 \*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  
Richmond Monmouth  
 20. UNDERTAKER ADDRESS  
Lyons  
Richmond

SUPPLEMENT

N. B. - This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH, so that it may be properly classified. Exact statement of OCCUPATION should be stated. GIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRE-REGISTERED.

14. INFORMANT Robert Portell  
 (Address) Elizabeth Mo  
 15. FILED 12/9/76 Chas. Martini  
 REGISTRAR

5-370 #10

I can not say positively the kind of Paralysis in this you refer to. The patient was unconscious when I first saw her and died 3 hours later. She had received no medical attention up to this time.

A. P. Missy

The date of birth and conjugal condition must be given and their certificate must be signed. Where nothing is known please write the word:—  
"Unknown"