

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

JAN 20 1927

37418

1. PLACE OF DEATH

County Caldwell Registration District No. 98 File No. 37418
 Township Kingston Primary Registration District No. 4060 Registered No. 14
 City Kingston (No. _____ 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 45 yrs. — mos. 25 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>—</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>—</u>		
7. AGE <u>45</u> YEARS	<u>0</u> MONTHS	<u>25</u> DAYS
		If LESS than 1 day, — hrs. or — min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Keeping house at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> (c) Name of employer <u>—</u>		

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1926

17. I HEREBY CERTIFY, That I attended deceased from Nov 11th 1926, to Dec 23, 1926, that I last saw her alive on Dec 23, 1926, and that death occurred, on the date stated above, at 11:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of the left Mammary.
50
 (duration) Don't know yrs. mos. ds.

CONTRIBUTING (SECONDARY) HT
 (duration) _____ yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Kingston, Caldwell Co. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Frank Smeltz

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

12. MAIDEN NAME OF MOTHER Jennie John

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

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

21. WHAT TEST CONFIRMED DIAGNOSIS? Physical
 (Signed) W. S. Shouse, M. D.
Dec 24, 1926 (Address) Kingston Mo.

14. INFORMANT B. J. Neiberger
 (Address) Washington Hotel, R.C. Mo.

15. FILED 12-28 1926 J. E. Hartside
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kingston Mo DATE OF BURIAL Dec 24 1926

22. UNDERTAKER Cowley and Abspanch ADDRESS Rob. Mo

CAUSE: _____

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, 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 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.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Adair Registration District No. 98 File No. _____
 Township Livingston Primary Registration District No. 4060 Registered No. 14
 City Livingston (No. _____) St. _____ Ward _____

2. FULL NAME Edw M. Smetty
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 28 - 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
45 | 0 | 25

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 _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1926

17. I HEREBY CERTIFY That I attended deceased from _____ 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:

 _____ (duration) _____ yrs. _____ mos. _____ da.
 CONCOMITANT (SECONDARY) _____
 _____ (duration) _____ yrs. _____ mos. _____ da.

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. D.
 _____, 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.)

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 Dec 25 1926 J. E. Gartside REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

PHYSICIANS should state OCCUPATION is very important.
 AGE should be stated properly classified. Exact statement of OCCUPATION is very important.
 ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.
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SUPPLEMENTARY

S-37418