

ORIGINAL

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF VITAL STATISTICS
STATE OF IOWA

5544

WAR 05 1927

1 PLACE OF DEATH

County Nodaway State Mo. #624 Registered No. 7
 Township Hopkins or Village 4375
 City Hopkins No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Clarice Arline Thompson

(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. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced. (write the word) child

16 DATE OF DEATH (month, day, and year) Feb. 23 1927

5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1927, to Feb. 23, 19276 DATE OF BIRTH (month, day, and year) Dec. 16-1926that I last saw her alive on Feb. 22, 19277 AGE Years _____ Months 2 Days 7 If less than 1 day, _____ hrs. or _____ min.and that death occurred, on the date stated above, at 4 A. m.

THE CAUSE OF DEATH* was as follows:

Broncho pneumonia

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 _____

(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY

(Secondary) _____

9 BIRTHPLACE (city or town) Hopkins, Mo. (State or country) _____

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

10 NAME OF FATHER Kent Thompson

18 Where was disease contracted

if not at place of death? _____

11 BIRTHPLACE OF FATHER (city or town) Hopkins, Mo. (State or country) _____Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? Clinical diagnosis12 MAIDEN NAME OF MOTHER Fern Williamson(Signed) J. S. Maxwell, M. D.2/24, 1927 (Address) Hopkins Mo.13 BIRTHPLACE OF MOTHER (city or town) Bedford, Ia. (State or Country) _____

*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.)

14 Informant Dr. Maxwell (Address) Hopkins, Mo.19 PLACE OF BURIAL, CREMATION OR REMOVAL Hopkins cem. Hopkins, Mo. DATE OF BURIAL Feb. 24 192715 Filed 2/24 27O. H. Sawyer
Registrar20 UNDERTAKER A. L. Stithum 2608ADDRESS Bedford 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.

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 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 CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Madison Registration District No. 624 File No. _____
 Township _____ Primary Registration District No. 4375 Registered No. 7
 City Stapkins (No. _____) St. _____ Ward _____

2. FULL NAME

Clairice Arlene Thompson
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If non-resident 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 S (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.
2 7

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 5/6, 1927 OH Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1927

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain's pneumonia
of unknown cause.
 (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) Hermap-ell, M. D.
676, 1927 (Address) Stapkins 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 _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

N. B.—Every item of information should be carefully supplied. 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 LA.

SUPPLEMENTARY

S-5549