

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

8980 ✓

1. PLACE OF DEATH

County Miss
 Township Ohio
 City Wyatt

Registration District No. 5709
 Primary Registration District No. 3745

File No. _____
 Registered 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 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/14 1927

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

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to March 14, 1927 that I last saw her alive on March 4, 1927, and that death occurred, on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/24/1866
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
 61 1 14

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 Paralysis
 SIA

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

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

9. BIRTHPLACE (CITY OR TOWN) Ohio county
 (STATE OR COUNTRY) Kentucky

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

10. NAME OF FATHER James Black

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

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio Co, Kentucky
 (STATE OR COUNTRY) _____

20. WAS THERE AN AUTOPSY? NO

12. MAIDEN NAME OF MOTHER Tobitha Lyons
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio Co Kentucky
 (STATE OR COUNTRY) _____

WHAT TEST CONFIRMED DIAGNOSIS? None
 (Signed) W Marshall, M. D.
3/15, 1927 (Address) Wyatt Mo

14. INFORMANT Ruby Brooks
 (Address) Charleston (R#4) 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.)

15. FILED 3/15, 1927. at Marshall
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Grove Cem,
DATE OF BURIAL 3/15 1927

20. UNDERTAKER Lair Salmon Co,
 ADDRESS Charleston Mo

N. B.—Every item of information should be carefully supplied. A true and correct statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PR 27 1927

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; Broncho-pneumonia* ("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 neoplasm); *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.; *Broncho-pneumonia* (secondary), 10ds. 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, septicaemia, 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.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Miss Registration District No. 569 File No. _____
 Township Ohio Primary Registration District No. 3-263- Registered No. _____
 City _____ (In _____) St. _____ Ward _____

2. FULL NAME Dora Francis Black
 (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 F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) M

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 Attil
 (Address) _____

15. FILED 3/18/27, 19____ Attil ashali
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-14 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ since on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis ascending
 CONTRIBUTORY (SECONDARY) 73W
 (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.)

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

20. UNDERTAKER _____ **ADDRESS** _____

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

Every item of information should be stated in plain terms. Exact statement of OCCUPATION should be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified.

SUPPLEMENTARY

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