1 PLACE OF DEATH

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

15922

County Primis Statle

Township Hollands Registration District No. 656 File No.

Primary Registration District No. 6281 Registered No.

Inc. Town or City Hollands (No. , St.; Ward)

2 FULL NAME Mary McC

If death occurred in a hospital or institution, give its NAME instead of street and number.

(a) Residence. No. Hemendale 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 fem

4 COLOR or RACE Coal

5 Single, Married, Widowed, or Divorced (write the word) Wife

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

6 DATE OF BIRTH 8 K Month Day 1 Year

7 AGE 35 Years Month — Days — If LESS than 1 day, ... hrs. or ..... min.

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

9 BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Mississippi (State or country) — —

12 MAIDEN NAME OF MOTHER May Jackson

13 BIRTHPLACE OF MOTHER (city or town) Mississippi (State or country)

14 Informant John McC
(Address) Herman Dale McC

15 Filed 5-10, 1927 James A. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 8 Month Day 1927 Year

17 I HEREBY CERTIFY, That I attended deceased from 5-3, 1927, to 5-4, 1927 that I last saw her alive on 5-4, 1927 and that death occurred, on the date stated above, at 4 a.m. The CAUSE OF DEATH* was as follows:
Ruptured Blood vessel in brain / She died 5-8-27
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis D.K. (duration) D.K. yrs. mos. ds.

18 Where was disease contracted if not at place of death? D.K.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptomia

(Signed) D.C. McLean, M. D.

5-9 1927 (Address) Yarbro ark

*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 Yarbro May 9 1927 DATE OF BURIAL

20 UNDERTAKER P. B. Tillman Blytheville ADDRESS

Burial or Transit Permit issued by Date of Issue

MARGIN RESERVED FOR BINDING

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. 4

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," "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 HOMOCIDAL, 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.—Certificates may 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, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.

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: Lawrence — Registration District No. 656 — File No.

Township: Falland — Primary Registration District No. 6281 — Registered No.

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Mary Mc

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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: D

4. COLOR OR RACE: B

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

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)

PARENTS

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 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ruptured blood vessel in lungs. She died May 8-1927

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

CONTRIBUTORY (SECONDARY) Arteriosclerosis

..... (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) ....., 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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

N. B. Registrars will find information concerning the Certificate of Death, including the Instructions to Registrars, on the back hereof. AGE should be given in years, months and days. Cause of Death should be in plain terms, so that it may be properly classified. Exact statement of facts is very important.

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