

JUN 27 1927

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

18102

1. PLACE OF DEATH

County Franklin Registration District No. 370 File No. _____
Township _____ Primary Registration District No. 4016 Registered No. 7
City Forest City (No. _____) St. _____ Ward _____

2. FULL NAME

Mrs Amintie M. Moberly
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. 2 mos. 11 ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Chas. Moberly</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 25 1864</u>		
7. AGE YEARS <u>64</u>	MONTHS <u>9</u>	DAY <u>6</u>
8. OCCUPATION OF DECEASED		IF LESS than 1 day, _____ hrs. or _____ min.
(a) Trade, profession, or particular kind of work <u>at home</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>at home</u>		
(c) Name of employer <u>self</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>White Cloud Mo</u>		
10. NAME OF FATHER <u>Mountain Bailey</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>		
12. MAIDEN NAME OF MOTHER <u>Mary Moberly</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>W Va</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 1 1927
17. I HEREBY CERTIFY, That I attended deceased from Jan-1-1927 to June-1-1927 that I last saw her alive on June-1-1927 and that death occurred, on the date stated above, at 6:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic valvular disease of heart

12/10
CONTRIBUTORY Chronic interstitial nephritis
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____
DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) F. E. Bullock M. D.
, 10 (Address) Forest City 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.)

14. INFORMANT (Address) <u>Chas. Moberly</u> <u>Forest City Mo</u>	19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Forest City Mo</u>	DATE OF BURIAL <u>June 3 1927</u>
15. FILED <u>6/9 1927</u> <u>F. E. Bullock</u> REGISTRAR	20. UNDERTAKER <u>Lester Poyjone</u>	ADDRESS <u>Oregon Mo.</u>

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

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.

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," "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.

**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 Wolk Registration District No. 370 File No.
 Township Forest City Primary Registration District No. 4216 Registered No. 7
 City St. Ward)
 2. FULL NAME Mrs. Admirette M. Moberly
 (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 foreign birth? yrs. mos. ds.

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) Aug 25, 1864
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 62 X 9 06
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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) June 1 19 27
 17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (that I last saw h. after on 19....., and that death occurred, on the date stated above, at m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

 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) 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.

14. INFORMANT (Address)
 15. FILED 6/2 19 27 F. C. Bullork REGISTRAR
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 ADDRESS 19
 20. UNDERTAKER ADDRESS

ADJUDICATING INK---THIS IS A PERMANENT RECORD

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 CAUSE OF DEATH in item of 9 carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-18102