

1 PLACE OF DEATH

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

20417

County Stone Registration District No. 847 File No. _____
Township Williams Primary Registration District No. 6112 Registered No. _____
Ino. Town or City Country (No. _____ St.; _____ Ward)

2 FULL NAME Sophron Belle Vaught
(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.

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR or RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married
6a If married, widowed, or divorced HUSBAND or (or) WIFE of Henry Vaught
6 DATE OF BIRTH June 9, 1896
Month _____ Day _____ Year _____
7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min. 30 11 26
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Missouri

10 NAME OF FATHER Marion B Denny
11 BIRTHPLACE OF FATHER (city or town) Madison County Arkansas
(State or country) _____
12 MAIDEN NAME OF MOTHER Mary Book
13 BIRTHPLACE OF MOTHER (city or town) Lamar County Texas
(State or country) _____

14 Informant M. B. Denny
(Address) High, Arkansas
15 Filed June 15, 1927 J. C. Chubbell
By E. B. Jones, Registrar

Burial or Transit Permit issued by _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 5 1927
Month _____ Day _____ Year _____

17 I HEREBY CERTIFY, That I attended deceased from 3-20 1925 to 6-6 1927
that I last saw h. alive on 6-4 1927
and that death occurred, on the date stated above, at 207
THE CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)
23 31 (duration) 6 yrs. _____ mos. _____ da.
CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ da.

18 Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of _____

What operation performed? _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) A. L. Carter M. D.
6-5 1927 (Address) Berryville

* 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 Williams Cemetery DATE OF BURIAL June 5 1927
20 UNDERTAKER Waynard Williams Berryville ADDRESS _____

Date of Issue Ark. R.H.D.1.

MARGIN RESERVED FOR BINDING

V. S. No. 4

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," "Exhaustion," "Heart failure," "Hemorrhage," "Insanition," "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.