

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

20535

16 1927

1. PLACE OF DEATH *adw*  
County *Novinger Mo* Registration District No. *5* File No. \_\_\_\_\_  
Township \_\_\_\_\_ Primary Registration District No. *4004* Registered No. *19*  
City *Novinger* (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *Charley Ellsworth*  
(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (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 *M.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *2*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Child*  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) *Novinger Mo*  
(STATE OR COUNTRY)

10. NAME OF FATHER *W M Ellsworth*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_  
12. MAIDEN NAME OF MOTHER *Beela Barber*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT *W M Ellsworth*  
(Address) *Novinger Mo*

15. FILED *7/12 1927* *J. S. Gaxhewler*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 12 1927*  
17. I HEREBY CERTIFY, That I attended deceased from *7/12*, 19*27*, to *7/12*, 19*27*  
(that I last saw him alive on *July 12*, 19*27*, and that death occurred, on the date stated above, at *2 a.m.*)

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Pre-natal delivery*

CONTRIBUTORY *abortion habit*  
(SECONDARY) (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, *Home*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*  
(Signed) *Josephine Gaxhewler*, M.D.

*7/12 1927* (Address) *Novinger 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 *Novinger Cemetery* DATE OF BURIAL *July 12 1927*

20. UNDERTAKER *Llewellyn Hon* ADDRESS *Novinger Mo*

N. B.—The 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*, *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," "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 Madison Registration District No. 2 File No. \_\_\_\_\_  
 Township Novinger Primary Registration District No. 4004 Registered No. 19  
 City Novinger (St. \_\_\_\_\_) (Ward \_\_\_\_\_)  
 2. FULL NAME Charley Ellsworth  
 (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 of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12 1927  
 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) \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

15. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 1927  
 17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, 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:  
Premature delivery  
17th mother has had spontaneous abortion  
stopped pains for 72 hrs.  
which were  
 CONTRIBUTORY (SECONDARY) were off pain returned  
 18. WHERE WAS DISEASE CONTRACTED Premature birth  
 IF NOT AT PLACE OF DEATH Child born 5 mi  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS 16th chest  
 (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 5/15 1927 J.S. Gachvel REGISTRAR  
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_  
 20. UNDERTAKER ADDRESS \_\_\_\_\_

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY DATE OF BIRTH in plain figures to which it may be properly classified. Exact statement of OCCUPATION is very important. FEE & REF. FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. VARS HALL NOT RE...

**SUPPLEMENTARY**

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