

AUG 18 1927

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

Do not use this space.

22314

1. PLACE OF DEATH

County *St. Francois*
Township *St. Francois*
City *St. Francois*

Registration District No. *773*
Primary Registration District No. *6018A*

File No. _____
Registered No. *86*
St. _____ Ward _____

2. FULL NAME

Lena Labrie

(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 *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Don't know*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 60

8. OCCUPATION OF DECEASED *Labour - at County Jail*
(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) *unknown*
(STATE OR COUNTRY)

10. NAME OF FATHER *unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *unknown*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *unknown*
(STATE OR COUNTRY)

14. INFORMANT *no records*
(Address)

15. FILED *7-27-27* *B. J. Robinson*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 1 1927*

17. I HEREBY CERTIFY That I attended deceased from *June 1*, 19*27*, to *July 1*, 19*27*
that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at *5:30 A.M.*

THE CAUSE OF DEATH** WAS AS FOLLOWS:
Chronic Diabetes Mellitus

59
57 *normal*
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*
(Signed) *Rappaport*, M. D.
7/1, 19*27* (Address) *Formville*

*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 *Catholic Cemetery* DATE OF BURIAL *July 27*

20. UNDERTAKER *Formville*
Formville

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.

typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., carcinoma, Sarcoma, etc., of* ———— (name original); "Cancer" is less definite; avoid use of "Tumor" (malignant neoplasm); *Measles, Whooping cough, Aortic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or incurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *etc.*; *Broncho-pneumonia* (secondary), *10ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Collapse," "Coma," "Convulsions," "Immobility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Infection," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all causes resulting from childbirth or miscarriage, as *puerperal septicemia,*" "*puerperal peritonitis,*"

State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF DEATH 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 head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus,* etc.) may be stated under the head of "Contributory." Recommendations on statement of cause of death were approved by Committee on Nomenclature of the American Medical Association.)

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

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.