

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

FEB 20 1928

26851^a

1. PLACE OF DEATH
 County Dallas Registration District No. 2-1-1
 Township North Benton Primary Registration District No. 1-1-1
 City Buffalo (No.) St. Ward)

2. FULL NAME Sarah C. Wise
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/4/1852

7. AGE YEARS MONTHS DAYS II LESS than 1 day, hrs. or min.
74 10 19

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/22 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Sept 23, 1927, that I last saw him alive on Sept 23, 1927, and that death occurred, on the date stated above, at 4:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of the Uterus
46 (duration) 2 yrs. 2 mos. 1 da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

10. NAME OF FATHER W K Jumper

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

12. MAIDEN NAME OF MOTHER Hogg

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

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. J. Lammie, M. D.
19 (Address) Poulsboerg MO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT John Wise
 (Address) Buffalo Mo.

15. FILED 2-9-28 Albert Booth
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lindley DATE OF BURIAL 9/25 1927

20. UNDERTAKER Raith & Jones ADDRESS Buffalo Mo.

Physicians should state exactly. Exact statement of OCCUPATION is very important. Cause of DEATH in plain terms, so that it may be properly classified.

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; Broncho-pneumonia* ("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 neoplasm); *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.; *Broncho-pneumonia* (secondary), 10ds. 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
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Kansas
Township Buffalo
City Buffalo (No. _____)

Registration District No. 241
Primary Registration District No. 4147

File No. _____
Registered No. 275-
St. _____ Ward _____

2. FULL NAME

Sarah C. Wise

(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 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 John Wise

6. DATE OF BIRTH (MONTH, DAY AND YEAR) NOV 4-1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 10 19

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) MO
(STATE OR COUNTRY)

10. NAME OF FATHER W. K. Jump

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

12. MAIDEN NAME OF MOTHER S. H. 1099

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

14. INFORMANT John Wise
(Address) Buffalo

15. FILED 5/10 1928 Nancy Munn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 1927

17. I HEREBY CERTIFY That I attended deceased from Sept 16 to Sept 23, 1927
that I last saw h. or alive on Sept 23, 1927, and that death occurred, on the date stated above, at 4:15 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cancer of the uterus

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) W. E. Jammon, M. D.

, 19 (Address) Louisburg 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.

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

19

20. UNDERTAKER _____ ADDRESS _____

CAUSE: _____ REGIS: _____
I NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
stated EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important.
in plain terms, so that it may be properly classified.
any supplied. A fee should be properly classified.

SUPPLEMENTARY

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