

ARKANSAS STATE BOARD OF HEALTH

Bureau of Vital Statistics
CERTIFICATE OF DEATH

29676

1 PLACE OF DEATH

County Butler

Township Gillus Bluff

Registration District No. 92

File No. _____

Inc. Town or

City _____ (No. _____)

Primary Registration District No. 5137

Registered No. _____

St.; _____ Ward)

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

2 FULL NAME Leas Hall

(a) Residence. No. Fagus Mo. 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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX _____ 4 COLOR or RACE _____ 5 Single, Married, Widowed, or Divorced (write the word)

16 DATE OF DEATH 10 20 19 27
Month Day Year

F. M. W.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from
10 1 19 27 to 10 20 19 27
that I last saw h r alive on 10 10 19 27

6 DATE OF BIRTH 5 7 1923
Month Day Year

and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH was as follows:

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

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.)

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

Typhoid Fever
(duration) _____ yrs. _____ mos. 30 da.

9 BIRTHPLACE (city or town) Mo.
(State or country)

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ da.

10 NAME OF FATHER Claud Hall

18 Where was disease contracted if not at place of death?

11 BIRTHPLACE OF FATHER (city or town) Mo.
(State or country)

Did an operation precede death? _____ Date of _____

12 MAIDEN NAME OF MOTHER Warren

What operation performed? _____

13 BIRTHPLACE OF MOTHER (city or town) Mo.
(State or country)

Was there an autopsy? _____

What test confirmed diagnosis?

14 Informant Claud Hall
(Address) Fagus Mo.

(Signed) J. P. Mills M. D.
19. (Address) _____

15 Filed 11/20, 1927 Scott Cook
Registrar

19. PLACE OF BURIAL, CREMATION, or REMOVAL Swivel Mill DATE OF BURIAL 10-20 1927

20 UNDERTAKER None ADDRESS _____

Burial or Permit issued by _____
Transit _____

Date of Issue _____

MARGIN RESERVED FOR BINDING

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," "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 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.