

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

ARKANSAS STATE BOARD OF HEALTH  
 VITAL STATISTICS  
 CERTIFICATE OF DEATH

36433  
 File No. A

County Dunklin Registration District No. 283  
 Township Duffalo Primary Registration District No. 5402 Registered No. \_\_\_\_\_  
 Inc. Town or City Cardwell, Mo. (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward)

2 FULL NAME Edward F. Lester  
 (a) Residence. No. Route # 1  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.

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR or RACE White 5 Single, Married, Widowed, or Divorced (write the word) \_\_\_\_\_  
 6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_  
 6 DATE OF BIRTH 9 15 1927  
 Month Day Year  
 7 AGE Years Month Days If LESS than 1 day, hrs. or mins. 3 7  
 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 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 22 1927  
 Month Day Year  
 17 I HEREBY CERTIFY, That I attended deceased from 12-16- 1927, to 12-22- 1927  
 that I last saw him alive on 12-22- 1927  
 and that death occurred, on the date stated above, at 1 P. m.  
 The CAUSE OF DEATH\* was as follows:

Septicemia of  
15B  
115; Meningitis and cause  
 (duration) yrs. mos. 12 ds.  
 CONTRIBUTORY Frigitania  
 (Secondary) (duration) yrs. mos. 6 ds.

9 BIRTHPLACE (city or town) (State or country) Mo  
 10 NAME OF FATHER James E Lester  
 11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky  
 12 MAIDEN NAME OF MOTHER Ora Frances  
 13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill

18 Where was disease contracted If not at place of death? Place of death  
 Did an operation precede death? no Date of \_\_\_\_\_  
 Was there an autopsy? no  
 What test confirmed diagnosis? \_\_\_\_\_  
 (Signed) R. B. Bridges M. D.  
Jan. 2 - 1928 (Address) Place quiet Ave

14 Informant J. E. Lester  
 (Address) Cardwell, Mo  
 15 Filed 4/24 19 28 W. A. Anderson  
 Registrar

\* 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 DATE OF BURIAL  
Cardwell, Mo 12-23 1927  
 20. UNDERTAKER ADDRESS  
Breckenridge Paragould  
Ark

Burial or Transit Permit issued by \_\_\_\_\_ Date of Issue \_\_\_\_\_

"Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.; "Dropsy," "Hic," "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 carbonic 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.)

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*.

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.

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,"



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