

25 1928

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

Do not use this space.
936-a

1. PLACE OF DEATH
County St. Louis Registration District No. 395 File No.
Township South 4th Primary Registration District No. 5551 Registered No.
City (No.) St. Ward)

2. FULL NAME Fanny Francis Bixendius
(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 w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27 - 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
101 7 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer wife
(b) General nature of industry, business, or establishment in which employed (or employer) ..
(c) Name of employer ..

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

10. NAME OF FATHER J. W. Bowlin

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

12. MAIDEN NAME OF MOTHER Went. Mo

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

14. INFORMANT Tony Bixendius
(Address) Blue Springs

15. FILED 7/12 1928 F. W. Guttb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 1928
17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1927, to Jan 13, 1928 that I last saw her alive on Jan 13, 1928 and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
107 A
97

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
(duration) 7 yrs. 7 mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED At place of death
IF NOT AT PLACE OF DEATH, DATE OF ..
DID AN OPERATION PRECEDE DEATH, no DATE OF ..
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical diagnosis
(Signed) W. B. Johnston, M. D.
, 19 (Address) Grain Valley, 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 Blue Springs DATE OF BURIAL 1-15-1928

20. UNDERTAKER W. B. With ADDRESS Blue Springs

N. B.—Every death must be properly classified. Exact statement of OCCASION OF DEATH must be given. CAUSE OF DEATH must be given.

Mo

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 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., *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 Jackson Registration District No. 395 File No. _____
 Township Waukegan Primary Registration District No. 5551 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Gannice Frances Bridgeline
 (a) Residence No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
 (Usual place of abode)
 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

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

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) unknown

14. INFORMANT _____
 (Address) _____

15. FILED 3-15-28 F. W. Smith
 19. _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1928

17. I HEREBY CERTIFY, That I attended deceased from _____ 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:

One pneumonia, broncho
 _____ (duration) _____ yrs. _____ mos. _____ da. X
 CONTRIBUTORY arterio sclerosis
 (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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) _____, 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. (See reverse side for additional space.)

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

20. UNDERTAKER _____ ADDRESS _____

19

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full term. INFORMATION is very important. REGISTER FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS DESCRIBED BY LAW

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