

Do not use this space.

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

1. PLACE OF DEATH  
 County St. Louis Registration District No. 583  
 Township Summer Primary Registration District No. 3754  
 City Messex Mo St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mary Elizabeth Groves  
 (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 Widow  
 (circle the word)

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 9 - 1876

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>81</u>	<u>3</u>	<u>7</u>	

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) Ohio  
 (STATE OR COUNTRY)

10. NAME OF FATHER Good

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

12. MAIDEN NAME OF MOTHER Lavinia

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

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY that I attended deceased from Dec 24, 1927 to Jan 16, 1928 that I last saw her alive on Jan 7, 1928, and that death occurred, on the date stated above, at \_\_\_\_\_

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apoplexy - rt side  
Rauwolfia poisoned  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Causes of uterus  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED 46  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? Signs of MI  
 (Signed) J. M. Perry, M. D.  
Jan 17, 1928 (Address) Pinckney 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.)

14. INFORMANT Sketcher Year DATE OF BIRTH \_\_\_\_\_  
 (Address) Mobile Miss. Mo

15. FILED Jan 26 1928 REGISTRAR Josephine Ellis  
Abel Moss

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Middle Point DATE OF BURIAL Jan 17 1928  
 20. UNDERTAKER Abel Moss ADDRESS Pinckney Mo

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.

## States Standard of Death

is and American Public Health  
Association.)

ation.—Precise statement of  
ortant, so that the relative  
pursuits can be known. The  
h and every person, irrespec-  
occupations a single word or  
ll be sufficient, e. g., *Farmer* or  
*Compositor*, *Architect*, *Locomo-  
ineer*, *Stationary Fireman*, etc.  
pecially in industrial employ-  
to know. (a) the kind of work  
of the business or industry,  
tional line is provided for the  
uld be used only when needed.  
*ner*; (b) *Cotton mill*; (a) *Sales-  
Foreman*, (b) *Automobile fac-  
orked on may form part of the  
ever return "Laborer," "Fore-  
Dealer,"* etc., without more  
as *Day laborer*, *Farm laborer*,  
etc. Women at home, who are  
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 occu-  
pation at beginning of illness. If retired from busi-  
ness, that fact may be indicated thus: *Farmer (re-  
tired, 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 orig-  
in; "Cancer" is less definite; avoid use of "Tumor"  
for malignant neoplasma); *Measles*, *Whooping cough*;  
*Chronic valvular heart disease*; *Chronic interstitial  
nephritis*, etc. The contributory (secondary or in-  
tercurrent) affection need not be stated unless im-  
portant. Example: *Measles* (disease causing death),  
29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.*  
Never report mere symptoms or terminal conditions,  
such as "Asthenia," "Anemia" (merely symptom-  
atic), "Atrophy," "Collapse," "Coma," "Convul-  
sions," "Debility" ("Congenital," "Senile," etc.),  
"Dropsy," "Exhaustion," "Heart failure," "Hem-  
orrhage," "Inanition," "Marasmus," "Old age,"  
"Shock," "Uremia," "Weakness," etc., when a  
definite disease can be ascertained as the cause.  
Always qualify all diseases resulting from child-  
birth 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 rail-  
way 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 undesir-  
able terms and refuse to accept certificates containing them.  
Thus the form in use in New York City states: "Certificate  
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, hemor-  
rhage, 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.