

WRITE PLAIN UNFADING INK---THIS IS A PERMANENT RECORD

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

Do not use this space.

10339

1. PLACE OF DEATH

County *St. Francois*
Township
City *Bismarck* (No.)

Registration District No. *771*
Primary Registration District No. *4462*

File No.
Registered No.
St. Ward

2. FULL NAME

Effie Jane Hall

(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. *10* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 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 *Bryan Hall*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *4-1-1912*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
15 11 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housekeeper*
(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) *Reynolds Co Mo*

10. NAME OF FATHER

H. W. Crumster

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Shannon Co Mo*

12. MAIDEN NAME OF MOTHER

Della Dole

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Waura Co Mo*

14.

INFORMANT (Address) *Geo W Crumster Bismarck Mo*

15.

FILED *3/18, 1928* *H. W. Gale* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-17* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *March 10*, 19*28*, to *March 17*, 19*28*, that I last saw him alive on *March 17*, 19*28*, and that death occurred, on the date stated above, at *9* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Facial Erysipelas

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *H. H. Huberson* M. D.

12. MAIDEN NAME OF MOTHER *Della Dole* 3/18, 1928 (Address) *Bismarck 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

Massena

DATE OF BURIAL

3-18 1928

20. UNDERTAKER

C. J. Hill

ADDRESS

Bismarck

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, 8 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 neoplasma); *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.

This baby came to Bismarck
from Keelington Mo, about 1 wk
b'fore her death. The attending
Phys. states she had a well
developed case of Erysipelas when
she arrived. Cause unknown,

F. W. Gale.

Local Reg.



WOODS DRUG STORE

R. J. WOODS

ELVINS.

MISS

For **R**

.....Address.....

S-10339

.....M. D. Reg.No.....

No.Date.....Address.....

**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 St. Francis Registration District No. 771 File No. _____
 Township _____ Primary Registration District No. 4462 Registered No. _____
 City Bismarck (No. _____) St. _____ Ward _____

2. FULL NAME

Effie Jane Hall
 (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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

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

AGE OF DECEASED	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

7. 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 _____

8. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) _____

9. NAME OF FATHER

10. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

11. MAIDEN NAME OF MOTHER

12. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

14.

INFORMANT _____
 (Address) _____

15.

FILED 3/18 1928

H. W. Gale
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17 1928

17.

I HEREBY CERTIFY That I attended deceased from _____, 19____ 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:

Facial Erysipelas

18. CONTRIBUTORY (SECONDARY)

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

Hill

ADDRESS

Bismarck Mo

SUPPLEMENTARY

218-X

BY, WITH

Every item of information should be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN'S name should be stated. REGISTRARS SHALL NOT SIGN CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED.

S-10339