

N. B.—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.

Form V. S. 1-50m-1-27-27

**COMMONWEALTH OF KENTUCKY**  
 State Board of Health  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

Retent  
 1051  
 5768  
 14104-1  
 File No. \_\_\_\_\_  
 Registered No. 18

1 PLACE OF DEATH  
 County Miss Ws  
 Vol. Pct. Durango Registration District No. 548  
 Inc. Town \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St., \_\_\_\_\_ Ward)  
 (If death occurred in a hospital or institution, give its NAME instead of street and number).

2 FULL NAME Elvira Grigsby  
 (a) Residence. No. \_\_\_\_\_ St., \_\_\_\_\_ Ward.  
 (Usual place of abode) (If not resident, 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  
 Married widowed  
 or divorced  
 (Write the word)  
 6a If married, widowed, or divorced:  
 HUSBAND of Arvon Grigsby  
 (or) WIFE of \_\_\_\_\_  
 6 DATE OF BIRTH Jan 23 1889  
 (Month) (Day) (Year)  
 7 AGE 39 yrs. 9 mos. 17 ds.  
 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

8 OCCUPATION OF DECEASED  
 (a) Trade, profession or particular kind of work at home  
 (b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (city or town) Miss  
 (State or country) \_\_\_\_\_  
**PARENTS**  
 10 NAME OF FATHER Jim Quinn  
 11 BIRTHPLACE OF FATHER (city or town) unknown  
 (State or country) \_\_\_\_\_  
 12 MAIDEN NAME OF MOTHER \_\_\_\_\_  
 13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
 (State or country) \_\_\_\_\_

14 (Informant) Arvon Grigsby  
 (Address) Durango Ws

15 Filed 4/20 1928 Mrs. Jessie Dillon  
 Registrar

**MEDICAL CERTIFICATE OF DEATH**  
 16 DATE OF DEATH April 19 1928  
 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, That I attended deceased from March 20 1928 to April 19 1928, that I last saw him alive on April 16 1928, and that death occurred on the date stated above at 9 P. M.  
 The CAUSE OF DEATH was as follows:  
Acute Anemia 145C  
12/10/28  
31/23/4503  
 (Duration) yrs. mos. 30 ds.  
 Contributory Child birth  
 (Secondary) \_\_\_\_\_ (Duration) yrs. mos. ds.

18 WHERE WAS DISEASE CONTRACTED  
 If not at place of death? \_\_\_\_\_  
 Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

19 Was there an autopsy? \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_  
 (Signed) J. T. Baker, M. D.  
4-20 28 (Address) Thickman, Ky.

\*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 OR REMOVAL New Albany Miss DATE OF BURIAL 4-20 1928  
 20 UNDERTAKER Barrett Stokes ADDRESS Thickman

**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*, *Compositor*, *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 years)*. 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 symptom 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, peritoncum*, 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 symp-

omatic), "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 Miss. Registration District No. 1851 File No. \_\_\_\_\_  
 Township James Bayou Primary Registration District No. 2758 Registered No. 18  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Elvira Grigsby  
 (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 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 Aaron Grigsby

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 23 - 1888

7. AGE YEARS MONTHS DAYS If LESS day, ... or  
40 9 26

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home (duration) yrs. mos. ds. 30  
 (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) Miss.

10. NAME OF FATHER Jim Oullis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Wagon

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

14. INFORMANT Aaron Grigsby (Address) Dorena mo

15. FILED \_\_\_\_\_, 19 \_\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 19 1928

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_  
Mar 20 1928 to Apr 19 1928  
 that I last saw h. \_\_\_\_\_ alive on Apr 16 1928 and that death occurred, on the date stated above, at \_\_\_\_\_  
9 P.M.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Acute Typhoid  
 CONTRIBUTORY Child birth (SECONDARY) (duration) yrs. mos. ds. \_\_\_\_\_

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) J. G. Baker, M. D.

420 1928 (Address) Hickman, Ky.

\*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

New Albany miss 4-20 1928

20. UNDERTAKER ADDRESS

Burrows & Stokes Hickman

N. B.-- 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

3-14104-1

death for Elvira Grigsby, who died April 19, 1928, and was at-  
tended by you. The certificate was sent in by our local registrar  
at Hickman, although the place of death is given as Doreno, Mo.

Will you be good enough to advise us whether this  
death really occurred in Kentucky or Missouri?

I thank you in advance for this information.

Very truly yours,

*J. F. Blackerby*  
J. F. Blackerby, State Registrar.

*Hickman, Ky.*  
*Dear Doctor:*

*The above men-  
tioned death occurred  
in Mo.*

*J. T. Baker*

NF

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may be  
copy

5(2)-14104-1