

N. B. - Every CAUSE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County Macon
 Township _____
 or _____
 Village _____
 or _____
 City Callao (NO. _____ St. _____ Ward)

Registration District No. 528 File No. 27856
 Primary Registration District No. 4314 Registered No. _____

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

2 FULL NAME Margarett Fletcher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
 4 COLOR OR RACE white
 5 SINGLE MARRIED WIDOWED OR DIVORCED
widowed
 (Write the word)

6 DATE OF BIRTH September 21, 1846
 (Month) (Day) (Year)

7 AGE 81 yrs. 11 mos. 7 ds.
 If LESS than 1 day, hrs. or min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
 (City or town, State or foreign country) Macon County

PARENTS
 10 NAME OF FATHER Residon Mott
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown
 12 MAIDEN NAME OF MOTHER Mary Finnell
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. Charles B. Smith
7149 Bennett Ave
 (Address) Chicago Ill.

15 Filed Aug 28, 1928
W. W. Welch
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 28, 1928
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 27, 1928, to Aug. 28, 1928, that I last saw her alive on Aug 27, 1928, and that death occurred, on the date stated above, at 7:0 m.
 The CAUSE OF DEATH* was as follows:

976 Paralysis
 (Duration) yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis
 (Secondary) (Duration) yrs. mos. ds.
 (Signed) W. W. Welch M. D.
Aug 29, 1928 (Address) Callao Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted if not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL ant Zion DATE OF BURIAL Aug 29, 1928
 20 UNDERTAKER H. A. Perry & Son ADDRESS Callao

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 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*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage, as "*Puerperal septicaemia*," "*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.)

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 Macon Registration District No. 3-28 File No.
 Township Callas Primary Registration District No. 4 314 Registered No.
 City Callas (No.) St. Ward

2. FULL NAME

(a) Residence. No. M Margarett Fletcher 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 M 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)

14.

INFORMANT (Address)

15.

FILED Aug 28 1928 W. M. Welch, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 28 1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis agitans (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?

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 ADDRESS

19

N. B.—Item of Inform. on should be carefully supplied. All info. stated EXACTLY. PHYSICIANS should state CAUSE of Inform. on should 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

S-27856