

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

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1. PLACE OF DEATH

County Prentiss
Township Wasson
City (No. _____) _____ St. _____ Ward _____

Registration District No. 186
Primary Registration District No. 52-62-9

File No. 14
Registered No. 186

2. FULL NAME

Janniel Beth

(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 (circle the word) single

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. 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Garrison (STATE OR COUNTRY) Mo

10. NAME OF FATHER Howard Beth

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

12. MAIDEN NAME OF MOTHER Alma Sturrett

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

14. INFORMANT (Address) _____

15. FILED _____, 19 _____ REGISTRAR G. F. Sturrett

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1929, to Jan 9 1929 that I last saw him alive on Jan 9 1929 and that death occurred, on the date stated above, at _____ M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Influenza
11/5 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Janniel (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at home

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? physical examination
(Signed) L. G. Hummel, M. D.
, 19 _____ (Address) Sparta 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 Garrison DATE OF BURIAL 19

20. UNDERTAKER G. F. Sturrett ADDRESS Garrison

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, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman, etc.* But in many cases, especially in industrial em-

necessary to know (a) the kind of (b) the nature of the business or in-
before an additional line is provided
statement; it should be used only when
amples: (a) *Spinner*, (b) *Cotton mill*,
(b) *Grocery*, (a) *Foreman*, (b) *Auto-*

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 house-
hold 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 be-
ginning of illness. If retired from business, that
fact may be indicated thus: *Farmer (retired, 6*
yrs.). For persons who have no occupation what-
ever, 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 ori-
gin; "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 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 "Asthemia," "Anemia" (merely symptomatic),
"Atrophy," "Collapse," "Coma," "Convulsions,"
"Debility" ("Congenital," "Senile," etc.), "Dropsy,"
"Exhaustion," "Heart failure," "Hemorrhage," "In-
anition," "Marasmus," "Old age," "Shock," "Ure-
mia," "Weakness," etc., when a definite disease can
be ascertained as the cause. Always qualify all
diseases resulting from childbirth or miscarriage, as
"PUERPERAL septi emia," "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 de-
termine definitely. Examples: *Accidental drown-*
ing; struck by railway train—accident; Revolver wound
of head—homicide; Poisoned by carbolic acid—prob-
ably 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 unde-
sirable 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, 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.

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