

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

2235

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

B 22 1929
54

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.

1. PLACE OF DEATH
 County Fayette Registration District No. 460 File No. _____
 Township Waverly Primary Registration District No. 4278 Registered No. 2
 City Waverly St. _____ Ward _____

2. FULL NAME Rouilla James Leaford
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED Husband or (OR) WIFE OF Att Leaford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-6-1881

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>47</u>	<u>3</u>	<u>19</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House wife
 (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) Fayette Co Mo

10. NAME OF FATHER Thomas R James

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

12. MAIDEN NAME OF MOTHER Maude Wallace

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-26-1929

17. I HEREBY CERTIFY, That I attended deceased from 12-23, 1928, to 1-25, 1929 that I last saw her alive on 1-25, 1929, and that death occurred, on the date stated above, at 12:09 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
186A
194B
23A about 14 yrs. 33 mos. 33 ds.

CONTRIBUTORY Fracture of upper end of femur
 (SECONDARY) (duration) _____ yrs. _____ mos. 33 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Geo A Kelling, M. D.
Waverly Mo (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Waverly Cem DATE OF BURIAL 1-26-1929

20. UNDERTAKER Willis Bros ADDRESS Waverly Mo

14. INFORMANT Att Leaford
 (Address) Waverly Mo

15. FILED 1-25 1929 Geo B Williamson
 REGISTRAR

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 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), 10th 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.

**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 Lafayette Registration District No. 465 File No.
Township Primary Registration District No. 4278 Registered No.
City Waverly (No.) St. Ward

2. FULL NAME

Parilla James Ledford
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE Sw. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Sm. (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 25 1929 19

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

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Pulmonary Tuberculosis
Fractured of upper of
leg
fall on ice
(duration) yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) Fractured of upper of leg
leg
(duration) yrs. mos. ds.

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? 185 DATE OF

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

185 WAS THERE AN AUTOPSY? 4

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS

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

(Signed) M. D.

, 19 (Address)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 1-26 19 29 Geo B. Williamson REGISTRAR

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRATION FEE SHALL NOT BE RECEIVED UNTIL THE COMPLETE FEE IS PRESCRIBED BY LAW

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