

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

5997

APR 24 1929

1. PLACE OF DEATH
 County De Witt Registration District No. 265 File No. 5375
 Township Osage Primary Registration District No. 5375 Registered No. 5375
 City Osage (No.) St. Osage Ward

2. FULL NAME Cornelia Nelson
 (a) Residence No. St. Ward
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9 19 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
74 6 29

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Home Keeping
 (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) North Carolina

10. NAME OF FATHER Wm Jenkins

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

12. MAIDEN NAME OF MOTHER Martha Wengerson

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

14. INFORMANT (Address)

15. FILED 19 29 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/2 1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Paralytic attack
not attended by physician
that is to say
 (duration) yrs. mos. ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 2/4 1929

20. UNDERTAKER ADDRESS

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

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.

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term on the
Planter, Physician, Compositor, Architect, etc.
tive Engineer, Civil Engineer, Stationary Fireman, etc.
But in many cases, especially in industrial employ-
ments, 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) *Colton mill*; (a) *Sales-*
man, (b) *Grocery*; (a) *Foreman*, (b) *Automobile fac-*
tory. The material worked on may form part of the
second statement. Never return "Laborer," "Fore-
man," "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 occu-
pation at beginning of illness. If retired from busi-
ness, that fact may be indicated thus: *Farmer (re-*
tired, 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

"Dropsy," "Hemorrhage," "Inanition," "Marasmus," "Shock," "Uremia," "Weakness," etc., when a
definite disease can be ascertained as the cause.
Always qualify all diseases resulting from child-
birth 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 rail-*
way 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 undesir-
able 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.

**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 De Witt
Township Orange
City (No.) St. Ward)

Registration District No. 268
Primary Registration District No. 3375

File No.
Registered No.

2. FULL NAME

Cornelia Nelson

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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.
73

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)

PARENTS
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 19 1927 Nelson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-2-29

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 stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
..... (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) Dr. Mc Carthy, M. D.
19 (Address) Salem 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.

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

20. UNDERTAKER ADDRESS
Jess Nelson

SUPPLEMENTARY

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

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

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