

PLACE OF DEATH Missouri STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

15504

County Oregon Registration District No. 632 File No. _____
 Township _____ Primary Registration District No. 4382 Registered No. _____
 Inc. Town or City Thayer (No. _____ St.; _____ Ward)

2 FULL NAME Pauline Catherine Price
 If death occurred in a hospital or institution, give its NAME instead of street and number.

(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. 6 mos. ds. New long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX fe 4 COLOR or RACE wh 5 Single, Married, Widowed, or Divorced (write the word) Single
 6a If married, widowed, or divorced HUSBAND of (or) WIFE of Single
 6 DATE OF BIRTH Oct-30- 128
 Month Day Year
 7 AGE Years 5 Months 11 Days 6 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) Infant
 (c) Name of employer _____

9 BIRTHPLACE (city or town) Thayer
 (State or country) Mo.

10 NAME OF FATHER A. Price

11 BIRTHPLACE OF FATHER (city or town) _____
 (State or country) Michigan

12 MAIDEN NAME OF MOTHER Dorthea Pecker

13 BIRTHPLACE OF MOTHER (city or town) _____
 (State or country) Indiana

14 Informant. A. Price
 (Address) Thayer, Mo.

15 Filed 4/10 1929 G. V. Shea
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4-6- 1929
 Month Day Year

17 I HEREBY CERTIFY, That I attended deceased from April 5- 1929 to _____, 19____
 that I last saw her alive on April 5- 1929
 and that death occurred, on the date stated above, at 6 a.m.
 The CAUSE OF DEATH was as follows:
 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.)

82 Congestion of Brain
 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
 (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

What operation performed? no

Was there an autopsy? no

What test confirmed diagnosis? _____
 (Signed) H. H. Morris M. D.
April 6 1929 (Address) Manumoth Sp. Coll.

19. PLACE OF BURIAL, CREMATION, or REMOVAL Thayer Cem. DATE OF BURIAL 4-7-1929

20 UNDERTAKER A. L. Carr ADDRESS Thayer Mo

Burial or Transit Permit issued by _____ Date of Issue _____

PHYSICIANS should state CAUSE OF DEATH. Plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse,"

"Old age," "Shock," "Uremia," "Weakness" when a definite disease can be ascertained 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.—Certificates may 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, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.*

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 Oregon Registration District No. 632 File No. _____
 Township Thayer Primary Registration District No. 4382 Registered No. _____
 City Thayer (No. _____) St. _____ Ward _____

2. FULL NAME

Pauline Catharine Price
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)
 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) _____

INFORMANT (Address) _____
 FILED 10 29 Le. Ahea REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/6 1929
 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:

Constriction of brain
all the information I can get
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 7400
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 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 _____ 19____
 20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

COMPLETE AS PRESCRIBED BY LAW

1929
#15504