

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

36947

1. PLACE OF DEATH

County Greene Registration District No. 375 File No. _____
 Township Wilson Primary Registration District No. 4195 Registered No. _____
 City Fardo (No. _____) St. _____ Ward _____

2. FULL NAME

Margaret Caroline Robertson

(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. mo. da. How long in U.S., if of foreign birth? yrs. mo. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 4 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER J. B. Giffert

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

12. MAIDEN NAME OF MOTHER Martha Elizabeth

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

PARENTS

14. INFORMANT Mr. J. B. Giffert
 (Address) Galesburg Ill.

15. FILED Nov 2 1929 REGISTERAR J. M. Stone

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 2nd 1929, to Nov 2nd 1929, that I last saw her alive on Nov 2nd 1929, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Angina Pectoris

(duration) 45 minutes

CONTRIBUTORY (SECONDARY) _____ (duration) _____

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? _____
 (Address) J. M. Stone, M. D. Fardo Ill.

*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 Rock Island Ill DATE OF BURIAL 11-6 1929

20. UNDERTAKER E. J. Robertson ADDRESS Fardo

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 employments, it is necessary to know (a) the kind of work

second statement. Never report "Business or industry," "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), 10 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.

**CENTRAL 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 Summit
Township Laredo
City Laredo (No. _____)

Registration District No. 328
Primary Registration District No. 4193

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Margaret Caroline Robertson
(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

MEDICAL CERTIFICATE OF DEATH

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

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

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

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.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8 - 1965

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1/ day, hrs. or min. 61 4 24

CONTRIBUTORY (SECONDARY) _____ (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 _____

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) _____, M. D.
, 19 (Address)

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)

*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.

14. INFORMANT _____ (Address)

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

15. FILED 11/4 1929 J. E. Stone REGISTRAR
M. C. Robertson

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

Project E m 5 m

April 14, 80

9:15 pm

Scott's car mark #2

S-36977