

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

2000

✓ 45

1. **PLACE OF DEATH**
 County Montgomery Registration District No. 593 File No. 45
 Township New Florence Primary Registration District No. 4357 Registered No. _____
 City New Florence St. _____ Ward _____

2. **FULL NAME** May Bell Hume
 (a) Residence. No. 1156 St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. 2 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 (write the word) married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Fred Hume

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

8. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 6 8

9. 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) housekeeping
 (c) Name of employer _____

10. BIRTHPLACE (CITY OR TOWN) Florissant
 (STATE OR COUNTRY) Missouri

11. NAME OF FATHER Edward Patterson

12. BIRTHPLACE OF FATHER (CITY OR TOWN) Florissant
 (STATE OR COUNTRY) Missouri

13. MAIDEN NAME OF MOTHER Louisa Davids

14. BIRTHPLACE OF MOTHER (CITY OR TOWN) Montgomery
 (STATE OR COUNTRY) Missouri

15. INFORMANT Allen Lee Hume Oregon
 (Address) Montgomery City Mo

16. FILED 1/10 1930 James O. Hume M.D.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

17. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16th 1930

I HEREBY CERTIFY That I attended deceased from Dec 4 1929 to Jan 16 1930
 that I last saw her alive on Jan 16 1930, and that death occurred, on the date stated above, at 11:56 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric Carcinoma
4 1/2 (duration) yrs. 6 mos. _____ ds.

CONTRIBUTORY (SECONDARY) Gall Stones
 (duration) 10 yrs. _____ mos. _____ ds.

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

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

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) O.W. Finley M.D.
2/1 1930 (Address) Montgomery City 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.)

21. PLACE OF BURIAL, CREMATION OR REMOVAL New Florence Cemetery DATE OF BURIAL 1/8 1930

22. UNDERTAKER Ed Bush New Florence
 ADDRESS _____

Exact statement of OCCUPATION is very important.

1930

PARENTS

711

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 *Nons*.

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 nephritis, etc.* The contributory (secondary or recurrent) affection need not be stated if unimportant. Example: *Measles* (disease causing death 29 ds.; *Bronchopneumonia* (secondary). Never report mere symptoms or terminal conditions such as "Asthenia," "Anemia" (merely relative), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile"), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Shock," "Uremia," "Weakness," etc., if no definite disease can be ascertained as the cause. Always qualify all diseases resulting from birth or miscarriage, as "PUERPERAL sepsis," "PUERPERAL peritonitis," etc. State whether surgical operation was undertaken. In cases of VIOLENT DEATHS state MEANS OF INJURY as ACCIDENTAL, SUICIDAL, or HOMICIDE, if probably such, if impossible to determine. Examples: *Accidental drowning; struck by way train—accident; Revolver wound a homicide; Poisoned by carbolic acid—probably*. The nature of the injury, as fracture of bone, and its 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 to the advantage of the public, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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ALL INFORMATION REQUESTED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Montgomery Registration District No. 1-9 3 File No. 457
 Township New Florence Primary Registration District No. 4 35-1 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Lucy Bell Kurne

(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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 1930

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

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 and above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8, 1858

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 6 8

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) _____

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) _____

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

15. FILED 2/1, 1930 James O. Helick REGISTERAR

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

S-2000

1/1/72