

MARGIN RESERVED FOR BINDING

V. S. No. 4

N. B.—WRITE 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. See instructions on back of certificate.

1 PLACE OF DEATH: Parsons 13535-a

2 STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

Township Virginia Registration District No. 655 File No. _____

Inc. Town or City Hamondale, Miss. Primary Registration District No. 5872 Registered No. _____

2 FULL NAME Dora White St.; _____ Ward) _____

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)
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 <u>Female</u>	4 COLOR or RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>married</u>		16 DATE OF DEATH Month <u>4</u> - Day <u>2</u> - Year <u>1930</u>	
6a If married, widowed, or divorced, HUSBAND of (or) WIFE of <u>J. H. White</u>				17 I HEREBY CERTIFY, That I attended deceased from <u>2</u> 19 <u>30</u> to <u>4-2</u> 19 <u>30</u>	
6 DATE OF BIRTH Month _____ Day _____ Year _____				that I last saw him alive on <u>4-2</u> 19 <u>30</u>	
7 AGE <u>52</u> Years	Months _____	Days _____	If LESS than 1 day, hrs. or min.	and that death occurred, on the date stated above, at <u>6 a.</u> m.	
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>H. wife</u> (b) General nature of industry, business or establishment in which employed (or employer) _____ (c) Name of employer _____				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.) <u>Pneumonia</u> <u>IIA</u> <u>109A</u>	
9 BIRTHPLACE (city or town) <u>Dunn</u> (State or country) _____				CONTRIBUTORY (Secondary) <u>Flu</u> (duration) yrs. mos. <u>5</u> ds.	
10 NAME OF FATHER <u>D. Knowl</u>				18 Where was disease contracted <u>at home</u> If not at place of death? _____	
11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____				Did an operation precede death? <u>no</u> Date of _____	
12 MAIDEN NAME OF MOTHER <u>D. Knowl</u>				What operation performed? <u>none</u>	
13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____				Was there an autopsy? <u>no</u>	
14 Informant <u>J. H. White</u> (Address) <u>Yarborough Park, B. 304</u>				What test confirmed diagnosis? <u>Symptomatic</u> (Signed) <u>D. C. McLean</u> M. P.	
15 Filed <u>4/15</u> 19 <u>30</u> <u>W. P. Kelley</u> <u>A. M. WASHBURN</u> Registrar				<u>4/2</u> 19 <u>30</u> (Address) <u>Yarborough Park</u>	
				19. PLACE OF BURIAL, CREMATION, or REMOVAL <u>Sisk Cemetery</u>	
				DATE OF BURIAL <u>4-2</u> 19 <u>30</u>	
				20 UNDERTAKER <u>Cobb Undertaking Co., Inc.</u>	
				ADDRESS <u>W. P. Kelley</u>	

Burial or Permit issued by Cobb Undertaking Co., Inc. Date of Issue 4/3/30

13535-a

4/3/30

Approved
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 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,"

"Coma," "Senile," "Hemiplegia," "Emphysema," "Heart failure," "Hemiplegia," "Asmus," "Old age," "Shock," "Anemia," "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 HOMOCIDAL, 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 Boonville Registration District No. 635- File No.
 Township Boonville Primary Registration District No. 3872 Registered No.
 City (No. St. Ward)

2. FULL NAME

Dora White
 (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 (write the word) m

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
32 | ✓ | ✓ | ✓ |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (as employer) (duration) yrs. mos. ds.
 (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)

14.

INFORMANT
 (Address)

15.

FILED 5/1 30 Max P. Kelly
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/2 19 30

17. I HEREBY CERTIFY That I attended deceased from
 19....., 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.

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)

*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

N. B.—Every death certificate should be stated EXACTLY as the facts appear, and should be properly certified. No alterations or additions should be made. The death certificate is a legal document and should be preserved as such. It is the duty of the registrar to see that the certificate is properly filled out and that the information is correct. The registrar shall not issue a certificate until they are complete and correct.

SUPPLEMENTARY

S-136362

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