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.

1. PLACE OF DEATH

County Newton Registration District No. 608

Township Newton Primary Registration District No. 6264

City (No. St. Ward)

File No. 40225

Registered No. 23

2. FULL NAME Mary Lou Brown

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5 1930

7. AGE Years Months 3. Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Granby R.R. 2. (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER H H Brown H H Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) R.R. 2 Granby (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Nell Nichols

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

14. INFORMANT Gale Brown (Address) Granby R.R. 2.

15. FILED Dec 3rd 1930 L. N. Pannell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 3 1930.

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd to Dec 3d 1930, to Dec 3d, 1930 that I last saw her alive on Dec 3d, 1930 and that death occurred, on the date stated above, at 12:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia

107 H

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 100 A

(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) J. W. Langley, M. D

Dec 3d, 1930 (Address) Granby 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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brown Cemetery

DATE OF BURIAL Dec 3, 1930

20. UNDERTAKER Jan Mutman

ADDRESS Granby Mo

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 ealthfulness of various pursuits can be known. The uestion applies to each and every person, irrespec- ve of age. For many occupations a single word or rm on the first line will be sufficient, e. g., *Farmer or lanter, Physician, Compositor, Architect, Locomo- e Engineer, Civil Engineer, Stationary Fireman*, etc. ut in many cases, especially in industrial employ- ents, it is necessary to know (*a*) the kind of work d also (*b*) the nature of the business or industry, d therefore an additional line is provided for the ter statement; it should be used only when needed. examples: (*a*) *Spinner*, (*b*) *Cotton mill*, (*a*) *Sales- n*, (*b*) *Grocery*, (*a*) *Foreman*, (*b*) *Automobile fac- y*. The material worked on may form part of the ond statement. Never return "Laborer," "Fore- n," "Manager," "Dealer," etc., without more cise specification, as *Day laborer, Farm laborer, borer—Coal mine*, etc. Women at home, who are gaged in the duties of the household only (not paid *usekeepers* who receive a definite salary), may be ered as *Housewife, Housework* or *At home*, and ldren, not gainfully employed, as *At school* or *At ne*. Care should be taken to report specifically occupations of persons engaged in domestic vice for wages, as *Servant, Cook, Housemaid*, etc. the occupation has been changed or given up on ount of the DISEASE CAUSING DEATH, state occu- ion at beginning of illness. If retired from busi- s, that fact may be indicated thus: *Farmer (re- d, 6 yrs.)* For persons who have no occupation atever, write *None*.

Statement of Cause of Death.—Name, first, DISEASE CAUSING DEATH (the primary affection h respect to time and causation), using always the e accepted term for the same disease. Examples: *ebrospinal fever* (the only definite synonym is pidemic cerebrospinal meningitis"); *Diphtheria* old use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho- pneumonia* ("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 STATEMENT BY PHYSICIAN.