

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. DEATH in plain terms, so that it may be properly classified.

MAY 27 1937

1. PLACE OF DEATH
County Stoddard Registration District No. 896 File No. 16845-1
Township Fidelity Primary Registration District No. 6098a Registered No. 16845-1
City Beaumont (No.) St. Ward)

2. FULL NAME Martha Paulina Watson
(a) Residence. No. St. Ward. (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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. - 19th - 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 6 7

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Berrie Mo

10. NAME OF FATHER Robt. Watson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

12. MAIDEN NAME OF MOTHER Lula Jeanette Stucken, 19 (Address) Beaumont

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

14. INFORMANT (Address)

15. FILED 5/12/37 Florence Allen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1431

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 6th

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:
Neuronal
108

(duration)..... yrs. mos. 15 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.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) J. F. Huddle M. D.

*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 Berrie, Mo. DATE OF BURIAL 4 - 7 1937

20. UNDERTAKER Berrie Undertaking Co. ADDRESS Berrie, Mo.

This certificate is made in lieu of one previously filed but misplaced by Registrar or other

STATE OF NEW YORK
JULY 1, 1917
OFFICE OF THE STATE COMMISSIONER OF HEALTH

Not to be filled in by the physician

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 worthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or name on the first line will be sufficient, e. g., *Farmer or Doctor, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. In many cases, especially in industrial employments, it is necessary to know (a) the kind of work done, and also (b) the nature of the business or industry, therefore an additional line is provided for the latter statement; it should be used only when needed. 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, Miner, Coal miner*, etc. Women at home, who are engaged in the duties of the household only (not paid *housekeepers* who receive a definite salary), may be reported as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on the day 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 at the time of death, write *None*.

Statement of Cause of Death.—Name, first, of the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the accepted term for the same disease. Examples: *Prospinal fever* (the only definite synonym is *epidemic cerebrospinal meningitis*); *Diphtheria* (never use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, 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.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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

16815-1
ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Stoddard Registration District No. 836 File No. _____
 Township Liberty Primary Registration District No. 6098a Registered No. 24
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Martha Pearlina Watson
 (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 A. (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.
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8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

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

19. UNDERTAKER (ADDRESS) _____

20. FILED 6/12 1932 Florence Allen Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-6-1931

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the day stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Opportunistic
lobar pneumonia
have metastasized
 Date of onset _____

Other contributory causes of importance:
108

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) _____, M. D.
 (Address) _____

5-16815-1