OCT 24 1931

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

PLACE OF DEATH

County Linn

Township North Salem
or
Village
or
City (NO. , St.: Ward)

Registration District No. 497

Primary Registration District No. 5672

File No. 31764

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Nellie Grant Kirk

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED ~~WIDOWED~~ OR DIVORCED (Write the word): Married

DATE OF BIRTH: Nov 17 (Month) (Day), 1869 (Year)

AGE: 62 yrs. 10 mos. 7 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Missouri.

PARENTS

NAME OF FATHER: William Maxey

BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia

MAIDEN NAME OF MOTHER: Christiana Bunch

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Missouri.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. F. Kirk

(ADDRESS) Purdin Mo

Filed , 191 , REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 9th (Month) 24th (Day), 1931 (Year)

I HEREBY CERTIFY, that I attended deceased from 9th 24th, 1931, to 9th 24th, 1931, that I last saw her alive on 24th 9th, 1931, and that death occurred, on the date stated above, at 4-15 p m.

The CAUSE OF DEATH* was as follows:

Incarcerated umbilical hernia.
Duration about 10 years

1220

(Duration) X yrs. mos. ds.

Contributory (SECONDARY) X

(Duration) X yrs. mos. ds.

(Signed) J. M. Boyles M. D.

9 , 191 (Address) Purdin Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death X yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? X

Former or usual residence

PLACE OF BURIAL OR REMOVAL: North Salem

DATE OF BURIAL: Sept 25 1931

UNDERTAKER: P H Chaffer

ADDRESS: Acting

# 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 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, 8 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, peritonaeum*, 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*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "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.)

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: Linn — Registration District No.: 497 — File No.:

Township: North Salem — Primary Registration District No.: 5672 — Registered No.:

City: ..... No. ..... St. ..... Ward)

2. FULL NAME Nellie Grant Kirk

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 17-1869

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	10	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

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

PARENTS

10. NAME OF FATHER William Mayes

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

12. MAIDEN NAME OF MOTHER Christiana Bunch

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

14. INFORMANT B. F. Kirk
(Address) Purdin mo.

15. FILED 11-6, 1931 — W. Belveaver — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-24 1931

17. I HEREBY CERTIFY, That I attended deceased from 9-24 1931 to 9-24, 1931 that I last saw h. alive on 9-24, 1931, and that death occurred, on the date stated above, at 4:15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Incarcerated umbilical hernia

(duration) abt 10 yrs. ..... mos. ..... ds.

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) J. M. Boyles, M. D
, 19 (Address) Purdin 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
North Salem	9-25 1931

20. UNDERTAKER	ADDRESS
H Chopper	Acting

SUPPLEMENTARY

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

S-31764