

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

1. PLACE OF DEATHCounty DouglasRegistration District No. 1071File No. 39087Township WallaPrimary Registration District No. 5398Registered No. 5

City..... (No.....) St..... Ward.....

2. FULL NAMELaura Jean Thompson(a) Residence. No. Squires Mo St. Ward.
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 59 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.**PERSONAL AND STATISTICAL PARTICULARS**3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND or (OR) WIFE OF Joseph Thompson.6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 18, 1852.7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 | 9 | 26**8. OCCUPATION OF DECEASED**(a) Trade, profession, or particular kind of work Housekeeper.(b) General nature of industry, business, or establishment in which employed (or employer) Own Home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(State or Country) Ala.10. NAME OF FATHER Berry A. Roberts.11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(State or Country) Unknown.12. MAIDEN NAME OF MOTHER Chandler13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(State or Country) Unknown.14. INFORMANT Mina Thompson
(Address) Squires Mo.15. FILED 12/15, 1932 E. J. Warden
REGISTRAR**MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 193217. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1932, to Dec 14, 1932, that I last saw her alive on Dec 10, 1932, and that death occurred, on the date stated above, at 7:30 A m.**THE CAUSE OF DEATH* WAS AS FOLLOWS:**Pneumonia
1932 (duration)..... yrs. mos. da.
Chronic Myocarditis
(SECONDARY) (duration)..... yrs. mos. da.**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.....

(Signed) M. C. Gentry M. D.12-14, 1932 (Address) Avd. 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 Murray Graveyard DATE OF BURIAL Dec 15, 1932.20. UNDERTAKER Neighbors ADDRESS Squires Mo.

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.

JAN 23 1933

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) *Colton 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 neoplasm); *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.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Douglas
Township Wells
City Wells (No. _____)

Registration District No. 1071
Primary Registration District No. 5-398

File No. _____
Registered No. 5-
St. _____ Ward _____

2. FULL NAME

Laura J. Thompson

(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) wid

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.

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)

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 12/15 1932. E. E. Warden Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-14 1932

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 _____ stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia
Heart state pneumonia
Bilateral
Cardiac failure

Date of onset _____

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. C. Gentry _____, M. D.
(Address) Wells

SUPPLEMENTARY

PHYSICIANS should s-
UPATION is very import- t.

Every item of information should be carefully supplied. AGE
DEATH in plain terms, so that it may be properly classif-
CAUSE

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

5-39087