

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.

FEB 27 1934

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

Do not use this space.

85

255

1. PLACE OF DEATH
 County Buchanan Registration District No. 1001
 Township W. 1st Primary Registration District No. 1001
 City W. 1st (No. 1001) St. W. 1st (Ward)

2. FULL NAME Twila May Hammer
 (a) Residence No. 2 St. W. 1st Ward North
 (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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 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) Dec. 5, 1919

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
14 1 14

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

9. BIRTHPLACE (CITY OR TOWN) Buchanan Co. (STATE OR COUNTRY)

10. NAME OF FATHER Bill Hammer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) W. 1st (STATE OR COUNTRY) W. 1st Co.

12. MAIDEN NAME OF MOTHER Kizzie Roberts

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

14. INFORMANT Mrs. Bill Hammer (Address) W. 1st, Mo.

15. FILED 1-19-34 John R. Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-19-34

17. I HEREBY CERTIFY That I attended deceased from 1-6-34 to 1-19-34 that I last saw her alive on 1-19-34 and that death occurred, on the date stated above, at 8:10 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Bronchitis Pneumonia
9-10-34 (duration) 5 weeks
10-1-34 (duration) 1 year
 CONTRIBUTORY (SECONDARY) near disease should be
metabolism (duration) ?

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: home

DID AN OPERATION PRECEDE DEATH: no DATE OF _____

WAS THERE AN AUTOPSY: no

WHAT TEST CONFIRMED DIAGNOSIS: findings
H. Clark (Signed) _____ M. D.
1/19, 1934 (Address) 307 P. S. Bldg

*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 Frazier DATE OF BURIAL Jan. 20 1934

20. UNDERTAKER H. A. Sullivan ADDRESS Lowry, Mo.

Revised United States Standard Certificate of Death

U. S. Census and American Public Health
Association.)

ent of Occupation.—Precise statement of is very important, so that the relative ss of various pursuits can be known. The plies to each and every person, irrespec-

For many occupations a single word or first line will be sufficient, e. g., *Farmer or hysician, Composer, Architect, Locomo- er, Civil Engineer, Stationary Fireman,* n many cases, especially in industrial em- it is necessary to know (a) the kind of also (b) the nature of the business or in- d therefore an additional line is provided or statement; it should be used only when s examples: (a) *Spinner*, (b) *Cotton mill,* an, (b) *Grocery*, (a) *Foreman*, (b) *Automo-*

The material worked on may form the second statement. Never return "Foreman," "Manager," "Dealer," etc., ore precise specification, as *Day laborer,* *er, Laborer—Coal mine,* etc. Women at b are engaged in the duties of the house- (not paid *Housekeepers* who receive a alary), may be entered as *Housewife,* k or *At home*, and children, not gainfully as *At school* or *At home*. Care should to report specifically the occupations of gaged in domestic service for wages, as *ook, Housemaid,* etc. If the occupation hanged or given up on account of the AUSING DEATH, state occupation at be- illness. If retired from business, that be indicated thus: *Farmer (retired,* 6 persons who have no occupation what- None.

ent of Cause of Death.—Name, first, the USING DEATH (the primary affection with time and causation), using always the ted term for the same disease. Examples: *al fever* (the only definite synonym is *cerebrospinal meningitis*"); *Diphtheria* 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 ori- gin; "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 inter- current) affection need not be stated unless im- portant. 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," "In- anition," "Marasmus," "Old age," "Shock," "Ure- mia," "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 de- termine definitely. Examples: *Accidental drown- ing; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—prob- ably 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 undesir- able 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, colic, childbirth, convulsions, hemor- rhage, 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.