

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.

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

36854

1 PLACE OF DEATH
County Clark
Township Bridges
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 645 File No. _____
Primary Registration District No. 5854 Registered No. 10

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

2 FULL NAME Norman Anne M. Ginnies

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH July 28 1934
(Month) (Day) (Year)
7 AGE 2 yrs. 10 mos. 10 ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (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 foreign country) MO

PARENTS
10 NAME OF FATHER Alvia M. Ginnies
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) MO
12 MAIDEN NAME OF MOTHER Callie Crawford
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) MO

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Callie Crawford
(Address) Hammersville MO

15 Filed 10/11 1934 J. T. White
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 Oct. 8 1934
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct. 7, 1934, to Oct. 8, 1934, that I last saw her alive on Oct. 8, 1934, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Cholera Infantum
1934
(Duration) 1 yrs. 9 mos. 3 ds.

CONTRIBUTORY (Secondary) 1934
(Duration) 1 yrs. 9 mos. 3 ds.
(Signed) _____ M. D.
, 191 (Address)

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death 1 yrs. 9 mos. 3 ds. In the State 1 yrs. 9 mos. 3 ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Callie Ridge, MO DATE OF BURIAL 10/19, 1934

20 UNDERTAKER Lee Hart ADDRESS Hammersville, 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 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) *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, 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, 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 septicaemia," "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 Ozark Registration District No. 645
 Township Primary Registration District No. 5854
 City (No) St. Ward)

File No.
 Registered No. 10

2. FULL NAME

Norma Ann Mc Ginnes

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 8 1934

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

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 date stated above, at..... m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 2 10

The principal cause of death and related causes of importance were as follows:
Cholera Infantum Date of onset

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

Other contributory causes of importance:

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

13. NAME

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

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

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)

15. MAIDEN NAME

Specify whether injury occurred in industry, in home, or in public place.

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

17. INFORMANT (ADDRESS)

Manner of injury
 Nature of injury

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

24. Was disease or injury in any way related to occupation of deceased? If so, specify

19. UNDERTAKER (ADDRESS)

(Signed) J. T. White, Health Officer, M. D.
 (Address) Quincy, Mo

20. FILED 19..... J. T. White Registrar

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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