

JUL 19 1935

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

19295

1. PLACE OF DEATH

County Cooper
Township Kelly
City Brunswick

Registration District No. 219
Primary Registration District No. 5299

File No. 2a
Registered No. 12
St. _____ Ward _____

2. FULL NAME

Emma Ann Oster

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>-</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 7th 1865</u>		
7. AGE YEARS <u>69</u>	MONTHS <u>8</u>	DAYS <u>14</u>
If LESS than 1 day, _____ hrs. or _____ min.		

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21st 1935

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1935, to June 21st, 1935, that I last saw her alive on June 21st, 1935, and that death occurred, on the date stated above, at 77th m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fractured neck of left femur

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

(duration) yrs. 4 mos. 1 da.

CONTRIBUTORY Abscess of bladder (SECONDARY)

(duration) yrs. 1 mos. 1 da.

9. BIRTHPLACE (CITY OR TOWN) White Hall
(STATE OR COUNTRY) Illinois

18. WHERE WAS DISEASE CONTRACTED at home

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF -

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? -

(Signed) W. H. Elliott, M. D.
, 19 (Address) Brunswick Mo.

10. NAME OF FATHER James Oster

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

12. MAIDEN NAME OF MOTHER Margaret Lakin

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

*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.)

14. INFORMANT Mr. C. R. Woodbridge
(Address) Brunswick Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL White Hall Illinois

DATE OF BURIAL June 23 1935

20. UNDERTAKER L. L. Parker

ADDRESS Brunswick Mo.

15. FILED 6/22 1935 - Halls P. P. 4

REGISTRAR

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.

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, 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, 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; Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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.

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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY SPACE.

1. PLACE OF DEATH

County Chaper Registration District No. 519
 Township Kelly Primary Registration District No. 3299
 City _____ (No. _____, St. _____, Ward _____)

File No. _____
 Registered No. 12

2. FULL NAME Emma Ann Otten

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 21, 1935

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

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

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

I last saw _____ 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.
69 8 14

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Fracture of neck of left femur.
caused by falling off back steps from porch.
 Date of onset _____

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 _____

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

What test confirmed diagnosis? _____ Was there an autopsy? _____

15. MAIDEN NAME _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury Feb 15, 1925

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

Where did injury occur? at home, Bancroton, Mo.
(Specify city or town, county, and State)

17. INFORMANT (ADDRESS) _____

Specify whether injury occurred in home, or in public place

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

Manner of injury fracture of neck of left femur
 Nature of injury _____

19. UNDERTAKER (ADDRESS) _____

24. Was disease or injury in any way related to occupation of deceased? _____

20. FILED 499 1935 Hattie Poxon Registrar

If so, specify _____
 (Signed) W. H. Elliott, M. D.
 (Address) Bancroton Mo

1920

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