

APR 16 1937

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

1. PLACE OF DEATH

County Clark
Township Des Moines
City St. Francisville (No. St. Ward)

Registration District No. 193
Primary Registration District No. 5270

File No. 11600
Registered No.

2. FULL NAME

Miss Amy Prost

(a) Residence: No. St. Francisville, Mo. 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 Female 4. COLOR OR RACE White 5. SINGLE; MARRIED; WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 18, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 2 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment, in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Francisville, Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER Charles L. Prost

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

12. MAIDEN NAME OF MOTHER Martha Spencer

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

14. INFORMANT Mrs. Clint Livesay
(Address) St. Francisville, Mo.

15. FILED 5/24 1937 H. F. Kircher REGISTRAR
By H. F.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 19, 1937

17. I HEREBY CERTIFY, That I attended deceased from Jan 1937 to March 19, 1937
that I last saw her alive on March 9, 1937, and that death occurred, on the date stated above, at 5:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Stomach and liver

(duration) 1 yrs. 4 mos. ds.
CONTRIBUTORY Gastric ulcer
(SECONDARY)

(duration) 10 yrs. mos. ds.

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) H. O. Strosider, M. D.

3/23, 1937 (Address) Wesley Iowa

*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 DATE OF BURIAL

Wolf Cemetery 3/21 1937

20. UNDERTAKER ADDRESS

H. F. Kircher Wayland, 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, 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*; *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 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," "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.

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

Do not use this space.

1. PLACE OF DEATH

County Clark Registration District No. 193 File No. 11600
 Township Des Moines Primary Registration District No. 5270 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Miss Amy Frost
 (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 (write the word) single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 19 1937

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 him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 4 day, hrs. or min. 74 2 1

Carcinoma of stomach and liver from gastric ulcers Date of onset 1927

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) _____ (Total time (years) spent in this occupation)

Other contributory causes of importance:
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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)
 Specify whether injury occurred in industry, in home, or in public place.

15. MAIDEN NAME _____

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

Manner of injury _____
 Nature of injury _____

17. INFORMANT (ADDRESS) _____

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

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

19. UNDERTAKER (ADDRESS) _____

20. FILED 3/24 1937 H. P. Kircher Registrar

W. H. Kieffer M. D.
 (Address) _____
 returned from state.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTAL

5-11600