

JUN 9 1939

CERTIFICATE OF DEATH

File No. 18847 Registered No. 176

1. PLACE OF DEATH: Cape Girardeau, Mo. Full Name: Katie M. Murphy. (a) Residence: Orau, Mo. Length of residence in city or town where death occurred: yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX: Female. 4. COLOR OR RACE: Negro. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow. 6A. IF MARRIED, WIDOWED, OR DIVORCED: HUSBAND OF (OR) WIFE OF Albert Murphy. 6. DATE OF BIRTH: Jan 13 1888. 7. AGE: 51 years, 4 months, 10 days. 8. OCCUPATION OF DECEASED: (a) Trade, profession, or particular kind of work: House wife.

15. DATE OF DEATH (MONTH, DAY AND YEAR): May 13 1939. 16. I HEREBY CERTIFY, That I attended deceased from May 7th 1939, to May 13th 1939. 17. THE CAUSE OF DEATH: was as follows:

Heart disease, myocarditis

CONTRIBUTORY (SECONDARY): Shock from surgical operation. (duration) 4 yrs. x mos. x ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't know Alabama. 10. NAME OF FATHER: Paul McKinnon. 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Alabama. 12. MAIDEN NAME OF MOTHER: Ellen Orial. 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Alabama.

18. WHERE WAS DISEASE CONTRACTED: IF NOT AT PLACE OF DEATH: Place of death. DID AN OPERATION PRECEDE DEATH: Yes DATE OF: May 8th '39. WAS THERE AN AUTOPSY: No. WHAT TEST CONFIRMED DIAGNOSIS: Physical. (Signed) J. D. [unclear] M. D. 19 (Address) Cape Girardeau Mo.

14. INFORMANT: Ethel Ann Edwards Daughter Orau Mo. 15. FILED: 1939 J. M. Thompson REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mc Mullins Cemetery. DATE OF BURIAL: 5/16 1939. 20. UNDERTAKER: P. J. Heusser Co. ADDRESS: Orau 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 im-

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, and last, of the disease causing death (the primary affection) in respect to time and causation), using always the accepted term for the same disease. Examples: *Myocardial fever, (the only definite synonym is epidemic cerebrospinal meningitis); Diphtheria and use of "Group"; Typhoid fever (never report*

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum, etc., Carcinoma, Sarcoma, etc., of.....* (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "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 septicæmia," "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; Reolster wound of head—homicide, Poisoned by carbonic 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, coliculis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyæmia, septicæmia, 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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FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

18247
Do not use this space.

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 125
 (b) Township 9 Primary Registration District No. 3009
 (c) City Cape (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Katie M. Murphy
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

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. |
|--------|-----------|----------|-----------|--|
| | <u>21</u> | <u>4</u> | <u>10</u> | |

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

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

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____, 19____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 13 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ 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:
Heart Disease Myocardial Date of onset _____
Shock from Surgical Operation
 Other contributory causes of importance: 121

Name of operation operation of appendectomy 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) W. H. Wessel M. D.
 (Address) Cape Girardeau Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 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 CAUSE OF DEATH is very important.

Local Registrar.

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