

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH
County Memphis
Township Portageville
or
Village _____
or
City Boakston (NO. _____ St. _____ Ward _____)

Registration District No. 607 File No. 10490
Primary Registration District No. 5504 Registered No. 2

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

FULL NAME Alley M Ryan

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH

Jan (Month) 4 (Day), 1898 (Year)

AGE

72 yrs. 3 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work House wife

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

BIRTHPLACE

(City or town, State or foreign country) Tenn

PARENTS

NAME OF FATHER

John Newbourn

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Tenn

MAIDEN NAME OF MOTHER

Jane White

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robbie E. Fish

(ADDRESS) Boakston

Filed 4-9, 1910, T. Hollaibek REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

April 8, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 711 W 25, 1910, to 711 W 25, 1910, that I last saw her alive on 711 W 25, 1910, and that death occurred, on the date stated above, at 3 P.M. The CAUSE OF DEATH* was as follows:

Old age

162 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory

(SECONDARY) Old age
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed)

H. H. H. H. H. M. D.
Miss Z. B. H. (Address) Portageville

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

Portageville

DATE OF BURIAL

4-9, 1910

UNDERTAKER

R. Young

ADDRESS

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, Sar-*

coma, 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 surgi al 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.)



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

PLACE OF DEATH New Madrid
County New Madrid Registration District No. 607 File No. 10490
Township Postoyeville or Village _____ Primary Registration District No. 5816 Registered No. 2
City _____ (NO. _____) St. _____ Ward _____
FULL NAME Allie M Ryan (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE Married MARRIED Widow WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH Jan 4 (Month) 18 (Day) 1838 (Year)

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Penn Pine

PARENTS

NAME OF FATHER	<u>John Newborn</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country)	<u>Penn Pine</u>
MAIDEN NAME OF MOTHER	<u>Jane, White</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<u>Penn Pine</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert M. ...
(ADDRESS) Rockton Mo

Filed 4-9 1911 T. Hollenbeck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 8 (Month) _____ (Day) _____ (Year) 1911

I HEREBY CERTIFY, that I attended deceased from Mar 25, 1911, to March 25, 1911, that I last saw him alive on Mar 25, 1911, and that death occurred, on the date stated above, at 3.1 m.

The CAUSE OF DEATH* was as follows:
Old age

Contributory (Secondary) Old age (Duration) 1 yrs. _____ mos. _____ ds.

(Signed) H. O'Kelly M. D. Address W. V. ...

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL 4-9 1911

UNDERTAKER Rob Young ADDRESS W. V. ...

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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