

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 Callaway
Township _____
or _____
Village _____
or _____
City Fulton Mo (NO State Hosp #1)

Registration District No. 104
Primary Registration District No. 3008

File No. 27565
Registered No. 141
St. 9 Ward

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

FULL NAME Mary Young

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH D.H. (Month) (Day) (Year)
AGE 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

DATE OF DEATH Aug 16, 1911
I HEREBY CERTIFY, that I attended deceased from March 9, 1911, to Aug 16, 1911, that I last saw her alive on Aug 16, 1911, and that death occurred, on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:

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

Chronic Gastritis
1 1/2 yrs. 2 mos. 2 ds.
(Duration) yrs. mos. ds.

BIRTHPLACE (City or town, State or foreign country) D.H.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.

PARENTS NAME OF FATHER D.H. BIRTHPLACE OF FATHER (City or town, State or foreign country) D.H. MAIDEN NAME OF MOTHER D.H. BIRTHPLACE OF MOTHER (City or town, State or foreign country) D.H.

(Signed) R.S. Magee M. D. 8-16-1911 (Address) Fulton Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Hospital Record (ADDRESS) Per Dr R.S. Magee Fulton Mo

*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 RECENT RESIDENTS) At place of death 5 yrs. 7 mos. 7 ds. In the State D.H. (mos. ds.)
Where was disease contracted if not at place of death? Former or usual residence Memphis Mo.

Filed 8/17 1911 REGISTER

PLACE OF BURIAL OR REMOVAL Memphis DATE OF BURIAL 8/17 1911
UNDERTAKER E.W. Henderson ADDRESS Fulton

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 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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
County Callaway
Township _____
or _____
Village _____
or _____
City Salmon

Registration District No. 104
File No. _____
Principal Registration District No. 3008
Registered No. 141
(NO. Sept. 21 St. 9 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Mary Young

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If widowed, state date)

DATE OF BIRTH Oct 9, 1911
(Month) (Day) (Year)

AGE 42
If LESS than 1 day, hrs. or min. _____
1 day, _____ hrs. _____ min. _____
yrs. mos. ds. or _____

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

BIRTHPLACE
(City or town, State or foreign country) _____

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Guard A. V. Mays
(ADDRESS) Salmon, Mo

Filed 8/17, 1911 A. Daily REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 16, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 9, 1911, to Aug 16, 1911, that I last saw her alive on Aug 15, 1911, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:
Chronic Gastritis

(Duration) _____ yrs. 2 mos. _____ ds.

Contributor (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. W. H. H. H. M.D.
8-16, 1911 (Address) Salmon, Mo.

*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 RECENT RESIDENTS)
At place of death yrs. 5 mos. 7 ds. In the State _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Usual residence Memphis, Mo.

PLACE OF BURIAL OR REMOVAL Memphis DATE OF BURIAL _____ 1911
ADDRESS Salmon
FUNERAL HOME W. H. H. H.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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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 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.)

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