

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

33481

PLACE OF DEATH
County Lacey
Township Bigfork
or
Village
or
City

Registration District No. 858
File No. 33481
Primary Registration District No. 6134
Registered No.
(NO. St. Ward)

FULL NAME Lavonia Nicholson

(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 WIDOWED OR DIVORCED single
(Write the word)

DATE OF BIRTH June 12 1910
(Month) (Day) (Year)

AGE 1 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country) Protem mo

PARENTS
NAME OF FATHER Jonicholson
BIRTHPLACE OF FATHER (City or town, State or foreign country) ark
MAIDEN NAME OF MOTHER Eva Keese
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(ADDRESS)

Filed Sept 20 1911 Jonicholson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 17 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 14, 1911, to Sept 17, 1911, that I last saw her alive on Sept 17, 1911, and that death occurred, on the date stated above, at 6 Am.

The CAUSE OF DEATH* was as follows:
Cerebrospinal Meningitis
7915

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

(Signed) Jonicholson M. D.
1911 (Address) Protem 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. 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 Protem mo DATE OF BURIAL Sept 17 1911
UNDERTAKER J. Keese ADDRESS Protem 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*, *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.)

HUGH STEPHENS, JEFFERSON CITY.



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

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

PLACE OF DEATH

County Taney
Township Big Creek
or
Village
or
City (NO. _____)

Registration District No. 858 File No. _____
Primary Registration District No. 6126 Registered No. _____
St.: _____ Ward _____

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

FULL NAME Lavonia Nicholson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)
DATE OF BIRTH June 12, 1910
(Month) (Day) (Year)
AGE 1 yrs. 3 mos. 5 da. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Protem Mo

PARENTS
NAME OF FATHER J. O. Nicholson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ark
MAIDEN NAME OF MOTHER Eva Keesee
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Nicholson
(ADDRESS) Protem mo

Filed Sept 20 1911 J. Nicholson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 17, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Sept 14, 1911, to Sept 17, 1911, that I last saw her alive on Sept 17, 1911, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:
cerebro spinal meningitis

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. O. Nicholson M. D.
Sept 20 1911 (Address) Protem 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. _____ 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 Protem Mo DATE OF BURIAL Sept 17 1911
UNDERTAKER J. T. Keesee ADDRESS Protem Mo

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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