

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

9285

PLACE OF DEATH  
County Miss  
Township St James  
or E. Prairie  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 567 File No. \_\_\_\_\_  
Primary Registration District No. 4394 Registered No. 19

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

FULL NAME Lucy Chapman

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED 1  
(Write the word)

DATE OF BIRTH June 9, 1869  
(Month) (Day) (Year)

AGE 44 yrs 2 mos 5 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Camden Ky Henderson

PARENTS  
NAME OF FATHER James P. Shelby  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Henderson  
MAIDEN NAME OF MOTHER Elizabeth Powell  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Henderson Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) S P Chapman  
(ADDRESS) East Prairie Mo

Filed Mar 15 1914 J S Davis  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 14, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 10, 1914, to Mar 14, 1914, that I last saw her alive on Mar 12, 1914, and that death occurred, on the date stated above, at 3:30 am.

The CAUSE OF DEATH\* was as follows:  
Dementia Paralytica  
83

(Duration) 2 yrs. \_\_\_ mos. \_\_\_ ds.

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

(Signed) S P Martin M. D.  
3-14, 1914 (Address) E Prairie 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 RESIDENT 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 Mo DATE OF BURIAL Mar 15, 1914

UNDERTAKER Lid Shelby ADDRESS East Prairie 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, 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, 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," "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 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; 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.)

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

Mississippi

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

County

Township

Village

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

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

FULL NAME

Lucy Chapman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female  
COLOR OR RACE white  
SINGLE MARRIED  
MARRIED

DATE OF DEATH Feb. 14, 1914  
(Month) (Day) (Year)

DATE OF BIRTH  
Satisfactory Information Supplied

AGE  
IF LESS than 1 day, hrs. min.

I HEREBY CERTIFY, that I attended deceased from  
and that death occurred, on the date stated above,  
The CAUSE OF DEATH\* was as follows:

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  
MAIDEN NAME OF MOTHER  
BIRTHPLACE OF MOTHER

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) S. P. Chapman  
(ADDRESS) East Prairie

Filed Mar 15, 1914, J. J. Davis REGISTRAR

Contributory  
(Signed) 191 (Address)

\*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 DATE OF BURIAL  
UNDERTAKER ADDRESS

SUPPLEMENTARY CERTIFICATE  
Satisfactory Information Supplied

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