

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

PLACE OF DEATH

County Jasper
Township _____
or _____
Village Purcell mo
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 394 File No. 37641
Primary Registration District No. 4578 Registered No. _____

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

FULL NAME Juanita - Solomon -

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>12</u> <u>7</u> <u>1915</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>1</u> mos. <u>-</u> ds.		if LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>159</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Purcell - 159</u>		
PARENTS	NAME OF FATHER <u>W. A. Solomon</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Saline Co. Mo</u>	
	MAIDEN NAME OF MOTHER <u>Lillian Zeyler -</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Jasper Co</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 7, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec - 6, 1915, to Dec 7, 1915, that I last saw her alive on Dec 6, 1915, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows:
a congenital paralysis (Cerebral) of the respiratory center due to premature birth

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

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

(Signed) W. A. Solomon M. D.
Dec 8, 1915 (Address) Albany 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 _____

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

(ADDRESS) _____
Filed 12/8 1915 Robert H Jordan
REGISTRAR no undertaker

PLACE OF BURIAL OR REMOVAL <u>Purcell cemetery</u>	DATE OF BURIAL <u>Dec 8</u> 191 <u>5</u>
UNDERTAKER <u>no undertaker</u>	ADDRESS _____

N. No. 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.

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*, *peritonaeum*, 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 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.)

REGISTRARS SHALL NOT RECEIVE
A FEE FOR CERTIFICATES UNTIL THEY
ARE COMPLETED AS PRESCRIBED BY
LAW1 PLACE OF DEATH
County Jasper
Township Purcell
Village Purcell
City PurcellRegistration District No. 394 File No. 14
Primary Registration District No. 14550 Registered No. 14
(NO. St. Ward)[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME Janita Solomon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED S.
(Write the word)6 DATE OF BIRTH
(Month) (Day) (Year)
Satisfactory Information Supplied7 AGE
hrs. mos. yrs. H LESS than 1 day. hrs. or min.?
Satisfactory Information Supplied8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Satisfactory Information Supplied9 BIRTHPLACE
(City or town, State or foreign country)PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)
SUPPLEMENTARY INFORMATION SUPPLIED14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. Solomon
(Address) Purcell Mo.15 Filed Dec 8 1916 Robert H Jordan
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
(Month) (Day) (Year)
Dec 7 191617 I HEREBY CERTIFY, that I attended deceased from
1916 to 1916
that I last saw him alive on 1916
and that death occurred, on the date stated above, at 11 m.
Satisfactory Information SuppliedThe CAUSE OF DEATH* was as follows:
Satisfactory Information SuppliedCONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
1916 (Address)
Satisfactory Information Supplied

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

18 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

19 PLACE OF BURIAL OR REMOVAL Purcell Cemetery DATE OF BURIAL Dec 7 191620 UNDERTAKER Mrs. P. Taylor ADDRESS Purcell MoOriginal file, date, DEC - 10 1915

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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37641
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 inter-
current) affection need not be stated unless important.
Example: *Measles* (disease causing death), 29ds.;
Bronchopneumonia (secondary), 10 ds. Never report
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"Asthenia," "Anaemia" (merely symptomatic), "Atro-
phy," "Collapse," "Coma," "Convulsions," "De-
bility" ("Congenital," "Senile," etc.), "Dropsy,"
"Exhaustion," "Heart failure," "Haemorrhage,"
"Inanition," "Marasmus," "Old age," "Shock,"
"Uraemia," "Weakness," etc., when a definite dis-
ease can be ascertained as the cause. Always qualify
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OF INJURY and qualify as ACCIDENTAL, SUICIDAL OR
HOMICIDAL, or as *probably* such, if impossible to de-
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