

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

Bull

1 PLACE OF DEATH
 County Lafayette
 Township _____ or _____
 Village _____ or _____
 City Lexington (NO. Howard St St. 2 Ward)

Registration District No. 461 File No. # 1936-0
 Primary Registration District No. 3024 Registered No. _____

2 FULL NAME Helen Ferguson

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female **4 COLOR OR RACE** Negro **5 SINGLE MARRIED WIDOWED OR DIVORCED** Single
(Write the word)

6 DATE OF BIRTH Feb 19 1915
(Month) (Day) (Year)

7 AGE 1 yrs. 11 mos. 6 ds. **If LESS than 1 day** hrs. or min.?

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

9 BIRTHPLACE
 (City or town, State or foreign country) Lexington Mo.

10 NAME OF FATHER William Ferguson
11 BIRTHPLACE OF FATHER Topeka Kans.
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER Grace Mazier
13 BIRTHPLACE OF MOTHER Biggsville Mo.
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Grace Mazier
 (Address) Lexington Mo.

15 Filed Feb 7 1917 J. Z. Cope
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 25 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 24 1917 to Jan 25 1917
that I last saw her alive on Jan 25 1917
and that death occurred, on the date stated above, at 1876 m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion
119C
6/6

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____
 (Duration) yrs. mos. ds.

(Signed) J. Bull M. D.
Jan 25 1917 (Address) Lexington Mo.

*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 Lexington Mo. **DATE OF BURIAL** Mar 26 1917

20 UNDERTAKER Ernest Heger **ADDRESS** Lexington 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) *Colton 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 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 LAW

1 PLACE OF DEATH

County *Lafayette*

Township *Lexington*

Village *Lexington*

City *Lexington*

Registration District No. *461*

File No. *11*

Primary Registration District No. *3024*

Registered No. *11*

St. *NO* Ward *NO*

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

2 FULL NAME

Nelie Johnson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *M*

4 COLOR OR RACE *B*

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *A*

16 DATE OF DEATH

Jan 25 1917
(Month) (Day) (Year)

6 DATE OF BIRTH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

, 191... to ... 191...
that I last saw *alive* on *Jan 25 1917*

7 AGE

If LESS than 1 day... hrs. or... min.?

and that death occurred, on the date stated above, at ... m.

8 OCCUPATION

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

The CAUSE OF DEATH* was as follows:

*Acute Indigestion
Wied during convulsions
Acute Indigestion
cause unknown*
Duration... yrs... mos... ds.

9 BIRTHPLACE

(City or town, State or foreign country)

CONTRIBUTORY

(Secondary)

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

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)

(Signed) *J. N. Ball* M. D.
Jan 25 1917 (Address) *Lexington, Mo.*

*State the Disease Causing Death, or, in death 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

20 DATE OF BURIAL

(M. C. G.) 191...

20 UNDERTAKER

ADDRESS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed

191...

Registrar

Original file, date

In Jan 17

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

Supplementary Information supplied

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.

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51926-A
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), 29ds.; *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.)