

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County Jesse
Township North Campbell Registration District No. 318 File No. 32959
or
Village Springfield Primary Registration District No. 5439 Registered No. 778
or
City Springfield (NO. R.F.D. # 6) St.: _____ Ward: _____
2 FULL NAME Mary C Owen

[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 White
5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH May 24 1889
(Month) (Day) (Year)

7 AGE 35 yrs. 5 mos. 5 ds.
If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry business, or establishment in which employed (or employer) 145

9 BIRTHPLACE
(City or town, State or foreign country) Missouri

PARENTS

10 NAME OF FATHER C C Grason
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee
12 MAIDEN NAME OF MOTHER Mary C Conley
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10/24 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10/23 1918 to 10/24 1918
that I last saw him alive on 10/23 1918
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:
Septicemia
(Duration) 2 ds.

CONTRIBUTORY (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W M S F Brown M. D.
10/25 1918 (Address) Springfield Mo

*State the Disease Causing Death, or, if 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 _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary C Grason
(Address) Springfield #6

15 Filed OCT 27 1918 Edwin F James Registrar

19 PLACE OF BURIAL OR REMOVAL East Lawn DATE OF BURIAL Oct 27 1918
20 UNDERTAKER W H Kinnear & Co ADDRESS 14 E Paul

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County
 Township Registration District No. File No.
 or
 Village Primary Registration District No. Registered No.
 or
 City (NO St. Ward)

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) 191..... (Year)

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

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

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

10 NAME OF FATHER
 (Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER
 (Duration) yrs. mos. ds.

13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

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

15 191.....
 Filed
 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....
 20 UNDERTAKER ADDRESS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191.....
 that I last saw h..... alive on..... 191.....
 and that death occurred, on the date stated above, at..... m.
 The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
 (Signed) (Duration) yrs. mos. ds.
 191..... (Address) M. D.

*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.....

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

16 11/21/1918
Hancock
303-306-

1. PLACE OF DEATH

County Franklin Registration District No. 318 File No. 118
Township Compbell Primary Registration District No. 5439 Registered No. 118
City (No.) St. Ward

2. FULL NAME

(a) Residence No. St. Ward
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/24 1918

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

17. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19....., that I first saw him alive on, 19....., and that death occurred, on the date stated above, at

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

137
pleure - Puerperal
pleuse
(duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. M. C. Brown, M. D.

1-20 - 1918 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

JAN 21 1919
FILED 1919
Edwin H. James REGISTRAR
Dollie Johnson

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

SUPPLEMENTARY

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

32959

"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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.