

Dr. Jolley

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

4440

1. PLACE OF DEATH
 County Audrain Registration District No. No File No. _____
 Township _____ Primary Registration District No. 3000 Registered No. _____
 City Mexico (No. 11) Carroll St. 3 Ward 47

2. FULL NAME Olga Byers Watts
 (a) Residence. No. 3 Carroll St., _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 3 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 31st, 1982

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
37 6 16

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) Brick Plant
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Audrain Co, Mo

10. NAME OF FATHER Neal Watts

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) mo.

12. MAIDEN NAME OF MOTHER Mary Phogmora

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Virginia

14. INFORMANT Char Watts (Address) Mexico Mo

15. FILED Feb 18 1920 Mexico Mo REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb, 17 19 20

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1920, to Feb 17, 1920, that I last saw him alive on Feb 17, 1920, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
POISONING (Wood Alcohol)
(accidental) (duration) yrs. _____ mos. 7 ds.

CONTRIBUTORY (SECONDARY) 1780 165 (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Frank Jolley, M.D. (Signed) Feb 18, 1920 (Address) Mexico, 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 Mexico Mo DATE OF BURIAL Feb 19 1920

20. UNDERTAKER R. C. Hector Bros ADDRESS Mexico Mo

N. E.—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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

ar pneumonia; Broncho-qualified, is indefinite);
ges, peritoneum, etc.,
..... (name ori-
definite, avoid use of "Tumor"
oplasms) Measles Whooping cough;
Chronic valvular heart disease; Chronic interstitial
nephritis, etc. The contributory (secondary
terocurrent) affection need not be stated unless im-
portant. Example: *Measles* (disease causing death),
29 ds.; *Bronchopneumonia* (secondary), *10 ds.*
Never report mere symptoms or terminal conditions,
such as "Asthenia," "Anemia" (merely symptom-
atic), "Atrophy," "Collapse," "Coma," "Convul-
sions," "Debility" ("Congenital," "Senile," etc.),
"Dropsy," "Exhaustion," "Heart failure," "Hem-
orrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uremia," "Weakness," etc., when a
definite disease can be ascertained as the cause.
Always qualify all diseases resulting from child-
birth 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 rail-
way 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.