

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

1 PLACE OF DEATH
County Jasper
Township Preston or Village Jasper or City Jasper (NO. _____ St. _____ Ward _____)
Registration District No. 410 File No. 1518
Primary Registration District No. 4243 Registered No. 3

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

2 FULL NAME Adelia ^{20y} Gill Campbell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE MARRIED Married WIDOWED OR DIVORCED (If wife the word)
6 DATE OF BIRTH May 20 1850
(Month) (Day) (Year)

7 AGE 72 7 yrs. 14 mos. 14 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
10 NAME OF FATHER Geo. W. Gill
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.
12 MAIDEN NAME OF MOTHER Nancy Ashham
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Campbell
(Address) Jasper Mo

15 Filed 191 W. Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan-4- 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec. 15- 1922, to Jan-4- 1923
that I last saw her alive on Jan-3- 1923
and that death occurred, on the date stated above, at 7-P m.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage.

(Duration) 74 yrs. 80 mos. 80 ds.

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Knott M. D.
1-4- 1923 (Address) Jasper, 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 New Hope Cem DATE OF BURIAL Jan 5 1923

20 UNDERTAKER Leeter Bros ADDRESS Jasper Mo

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.

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.)

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Jasper State MISSOURI Registered No. _____
 Township Preston or Village 4243 _____ or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Adelia Gill Campbell
 (a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
 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.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) _____

7 AGE Years _____ Months _____ Days _____
 IF LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(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 _____

9 BIRTHPLACE (city or town) _____
(State or country)

10 NAME OF FATHER _____
 11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)
 12 MAIDEN NAME OF MOTHER _____
 13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant _____
(Address)

15 Filed 3-23 1923 Asst. Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY that I attended deceased from _____, 19____, to _____, 19____,

that I last saw h..... alive on _____, 19____,

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

The CAUSE OF DEATH* was as follows:

Cerebral Embolism
due to Chronic
Interstitial Nephritis.
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____

18 Where was disease contracted _____ (duration) _____ yrs. _____ mos. _____ ds.
 If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) W. H. Knott, M. D.

, 19 (Address) 7-8-23 Jasper, Mo.

* State the DISEASE CAUSING DEATH, or in death 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 _____

SUPPLEMENTAL

129

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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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, septicoemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

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ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.