

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

1926

1. PLACE OF DEATH

County Montgomery Registration District No. 594 File No. _____
 Township Laurie Primary Registration District No. 7352 Registered No. One
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Sultana R Godley
 (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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. If Married, Widowed, or Divorced HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-24-1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 6 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeping
 (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) Virginia

PARENTS

10. NAME OF FATHER Wesley Godley

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

12. MAIDEN NAME OF MOTHER Sultana R Farreland

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

14. INFORMANT Pete Godley (Address) McNittuck Mo

15. FILED 1-9-1923 O. P. Kauschulbach REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1923

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 9, 1923 (the last saw her alive on Jan 8, 1923, and that death occurred, on the date stated above, at 8 a.m. in _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Gastritis

(duration) yrs. mos. ds. 16

CONTRIBUTORY (SECONDARY) Benign tumor of Stomach

Probably (duration) yrs. mos. ds. 10

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

19. Did an OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical
 (Signed) O. P. Kauschulbach, M. D.

1-9-1923 (Address) Rhine land 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

Jan 11 1923

20. UNDERTAKER ADDRESS Ed. Hattmeyer Rhine land 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) *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, 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.

1 PLACE OF DEATH

County Montgomery
 Township Lotire
 or
 Village _____
 or
 City _____ (No. _____, St.; _____ Ward)

594
 5788B

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of Missouri Registered No. One

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

2 FULL NAME

Suttana R. Godley

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH: June 24, 1852
 (Month) (Day) (Year)

7 AGE 70 yrs. 6 mos. 16 ds. IF LESS than 1 day, ___ hrs. or ___ min. 7

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

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Hiram Godley

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Suttana Farceland

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pete Godley
 (Address) McKittick Mo

15 Filed 1-9 1923 O. R. Rauschelbach REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9, 1923
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 9, 1923, that I last saw her alive on Jan 8, 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) ___ yrs. ___ mos. 6 ds.

Contributory Benign tumor of stomach
 (Secondary) Probably (Duration) 10 yrs. ___ mos. ___ ds.

(Signed) O. R. Rauschelbach, M. D.

Jan 9, 1923 (Address) Rhine Land Mo

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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 Home Country DATE OF BURIAL Jan 11, 1923

20 UNDERTAKER Ed Kottmeyer ADDRESS Rhine Land Mo

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