

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

**1 PLACE OF DEATH**

County Saline

Township.....  
or  
Village.....  
or  
City Slater (NO..... St..... Ward)

Registration District No. 799 File No. 8507

Primary Registration District No. 4479 Registered No. 11

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

**2 FULL NAME** Lucy Ann Washington

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** 7 **4 COLOR OR RACE** W **5 SINGLE MARRIED WIDOWED OR DIVORCED** married  
(Write the word)

**6 DATE OF BIRTH** Jan 1  
(Month) (Day) (Year)

**7 AGE** 55  
If LESS than 1 day,.....hrs. or.....min.?  
.....yrs.....mos.....ds.

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

**9 BIRTHPLACE**  
(City or town, State or foreign country) Saline Co Mo

**10 NAME OF FATHER** Geo Washington

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

**12 MAIDEN NAME OF MOTHER** ✓

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

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) John Washington  
Slater Mo  
(Address)

**15** 2-24 23 W. M. Funt  
Filed..... 191..... Registrar

**MEDICAL CERTIFICATE OF DEATH**

**10 DATE OF DEATH** Feb 23 1923  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY**, that I attended deceased from Dec. 8 1922, to Feb 23 1923 that I last saw her alive on Feb 23 1923 and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:  
Hodgkins Disease  
7 1/2  
(Duration) yrs 6 mos. 2 ds.

**CONTRIBUTORY**  
(Secondary) 15  
(Duration) yrs.....mos.....ds.  
(Signed) W. E. Lockwood M. D.  
Feb 23 1923 (Address) Slater 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** Rehoboth Cemetery **DATE OF BURIAL** Feb 25 1923

**20 UNDERTAKER** Will Brothers **ADDRESS** Slater

CAUSE OF DEATH IN BIRTH FORM, 1907

# 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, Composer, 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 Saline State MISSOURI. 799 Registered No. 7537  
 Township \_\_\_\_\_ or Village 4479 or \_\_\_\_\_  
 City Slater No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

**2 FULL NAME** Lucy Ann Washington

(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**

<b>3 SEX</b> <u>m</u>	<b>4 COLOR OR RACE</b> <u>col</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (write the word) <u>m</u>
<b>5a</b> If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____		
<b>6 DATE OF BIRTH</b> (month, day, and year) <u>1-1-1868</u>		
<b>7 AGE</b>	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) \_\_\_\_\_

<b>PARENTS</b>	<b>10 NAME OF FATHER</b> _____
	<b>11 BIRTHPLACE OF FATHER</b> (city or town) _____ (State or country) _____
	<b>12 MAIDEN NAME OF MOTHER</b> _____
	<b>13 BIRTHPLACE OF MOTHER</b> (city or town) _____ (State or country) _____

**14 Informant** \_\_\_\_\_  
 (Address) \_\_\_\_\_

**15** Filed 2-24, 1923 mm Tuttle  
11-2134 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** (month, day, and year) Feb 23 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:

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**CONTRIBUTORY** \_\_\_\_\_  
(SECONDARY)

\_\_\_\_\_ (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? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19 (Address)

\* 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** \_\_\_\_\_

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

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, Composer, 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*.

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atic), "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.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

7537