

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

PLACE OF DEATH

County Texas

Township Burdick

Village Cabool

City _____

Registration District No. 862

Primary Registration District No. 6185

File No. _____

Registered No. 7

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

FULL NAME

Infant of Ollie Southard

PERSONAL AND STATISTICAL PARTICULARS

SEX Girl COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (If wife the word)

DATE OF BIRTH Feb 7, 1923
(Month) (Day) (Year)

AGE _____ If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. 8 hrs or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Cabool mo

NAME OF FATHER Ollie Southard

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

MAIDEN NAME OF MOTHER Adamsville Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed Feb 8, 1923 A. H. D. v. g

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 7, 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 7, 1923, to Feb 7, 1923, that I last saw her alive on Feb 7, 1923, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth

159 (Duration) _____ yrs. _____ mos. 8 hrs

Contributory (Secondary) _____

(Signed) J. M. Coats M. D.

(Address) Cabool mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 _____

PLACE OF BURIAL OR REMOVAL Cabool DATE OF BURIAL Feb 8, 1923

UNDERTAKER Hayward E. D. Cabool ADDRESS _____

CRUISE OF DEATH IN plain terms, so that it may be properly classified.

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 "Asthemia," "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 Texas State MISSOURI 862 Registered No. _____
 Township Burdine or Village 6135 or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Infant of Ellie Southard
 (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

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

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

6 DATE OF BIRTH (month, day, and year) Feb 7 1923

7 AGE Years Months Days If LESS than 1 day, - P. 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 John McCall
 (Address) Cubool mo

15 Filed Feb 8, 1923 A. N. Dunc
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

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:

Premature birth
16/00 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

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 _____ 19____

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTAL

TION is very important. See instructions on back of certificate.

Exact statement of

carry in plain terms, so that it may be properly classified.

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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, 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.