

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

✓ 7934

**1. PLACE OF DEATH**

County Bone Registration District No. 72 File No. \_\_\_\_\_  
 Township Centralia Primary Registration District No. 5711 Registered No. 14  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Savertia Stephens  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX** Female **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married  
**5A. IF MARRIED, WIDOWED, OR DIVORCED**  
 HUSBAND OF James Howard Stephens  
 (OR) WIFE OF \_\_\_\_\_  
**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) 7-19-1845  
**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
77 7 22 \_\_\_\_\_  
**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) 19  
**17.** I HEREBY CERTIFY, That I attended deceased from Oct. 17 - 1923, to Mar. 11 - 1923  
 that I last saw her alive on Oct. 17 - 1923, and that death occurred, on the date stated above, at 56 m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Bronchitis  
1965 yrs. mos. ds.  
**CONTRIBUTOR** 998  
 (SECONDARY) \_\_\_\_\_ yrs. mos. ds.

**9. BIRTHPLACE** (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Missouri  
**10. NAME OF FATHER** Louis Roberts  
**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ky  
**12. MAIDEN NAME OF MOTHER** Nellie Logsdon  
**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Virginia

**18. WHERE WAS DISEASE CONTRACTED** \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
**19. DID AN OPERATION PRECEDE DEATH?** \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Chas. W. Gustene, M. D.  
 , 19 (Address) Centralia, 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.)

**14. INFORMANT** Oliver A. Stephens  
 (Address) Centralia Mo  
**15. FILED** 3/12 1923 J. H. Hickerson  
 REGISTRAR

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Union Church Cem **DATE OF BURIAL** Mar 13 1923  
**20. UNDERTAKER** M. S. Bush **ADDRESS** Centralia 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, 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) *Colton 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 neoplasma); *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.

# STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

1 PLACE OF DEATH  
 County Bonne 72 State MISSOURI Registered No. \_\_\_\_\_  
 Township Centralia 5111 or Village \_\_\_\_\_ or  
 City \_\_\_\_\_ No. \_\_\_\_\_ St., \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lucretia Stephens mar. 1923  
 (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

### MEDICAL CERTIFICATE OF DEATH

3 SEX 7 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

16 DATE OF DEATH (month, day, and year) May. 11 1923

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

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,

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

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.

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

The CAUSE OF DEATH\* was as follows:

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work \_\_\_\_\_

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

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

CONTRIBUTORY (SECONDARY)

(c) Name of employer \_\_\_\_\_

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

9 BIRTHPLACE (city or town) \_\_\_\_\_  
 (State or country)

18 Where was disease contracted  
 If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

10 NAME OF FATHER

Was there an autopsy? \_\_\_\_\_

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
 (State or country)

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

12 MAIDEN NAME OF MOTHER

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

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
 (State or country)

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

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15 Filed 3/12, 1923 J. C. HICKERSON  
 11-8184 REGISTRAR

20 UNDERTAKER ADDRESS

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SUPPLEMENTAL

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