

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

4856

**1. PLACE OF DEATH**

County LAWRENCE. Registration District No. 1054 File No. \_\_\_\_\_  
 Township SPRING. Red Oak Primary Registration District No. 5031 Registered No. 2  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** ALMANDA GUINN:

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX FEMALE 4. COLOR OR RACE WHITE. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) WIDOWED

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 15 1924.  
 17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1924, to Feb. 15 1924  
 that I last saw h. ex. alive on Feb. 3 1924, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Chronic Rheumatism,  
new septic condition from  
broken femur!  
 (duration) yrs. mos. da. severe yes!  
 CONTRIBUTORY (SECONDARY) Broken femur!  
 (duration) yrs. mos. da. \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-3 1847.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
77 10 14.

**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) TENNESSEE.  
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_

10. NAME OF FATHER JOHN MCLAMORE.

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) W. S. Bruner M. D.  
2/17, 1924 (Address) Miller, Mo

12. MAIDEN NAME OF MOTHER UNKNOWN.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) DO! Mo.  
 (STATE OR COUNTRY)

\*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 MRS. HENRY UPP.  
 (Address) RED OAK MO:

19. PLACE OF BURIAL, CREMATION, OR REMOVAL RED OAK, MO; DATE OF BURIAL 2/17/1924/

15. FILED 2-17-24 W. W. Weber  
 REGISTRAR

20. UNDERTAKER E. J. CALDWELL. ADDRESS LOCKWOOD, MO:

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE 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) *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 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 child-birth 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.

Mr Erbe,

Jefferson City Mo

Dear Sir,

I rec'd Certificate of Almarsda Guinn

Requesting information of cause of Broken Bone  
she fell and broke a Bone in her knee. she  
was a near Neighbor of mine. she was Helples  
But tried to move her self and fell.

Wm Weber

P.S. you Please fill in Certificate,

OF MISSOURI

City of Jefferson

April 17, 1924.

5(2) - 4886

Dear Registrar:-

The government at Washington strictly demands the information called for on the enclosed supplemental. Therefore it will be a great accommodation to us to have the supplemental returned at the very earliest moment.

Are you sure that you are placing every birth and every death on record in your Registration

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

**1. PLACE OF DEATH**

County Lawrence Registration District No. 1054 File No. ....  
 Township Red oak Primary Registration District No. 5631 Registered No. 2  
 City ..... (No. ....) St. .... Ward)

**2. FULL NAME**

Amanda Gunn  
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Use the word) M

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 3 - 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
77 10 14

**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) .....

PARENTS

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 Apr 28 1924 Wm Weber REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1924

17. I HEREBY CERTIFY, That I attended deceased from .....  
 to ..... 19.....  
 that I last saw h.....  
 death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Pneumonia  
and septic conditions  
from broken femur  
 (duration) ..... yrs. .... mos. .... ds.  
 CONTRIBUTORY Broken femur  
 (SECONDARY) (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH.....  
 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 .....

E. Caldwell - Lockwood mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

3 stated EXACTLY. PHYSICIANS should state fact statement of OCCUPATION is very important.

CAUSE OF DEATH in plain terms, so that it may be properly identified.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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BY PHYSICIAN.

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