

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

15206 ^a

PLACE OF DEATH
County Gaillard Registration District No. 469 File No. _____
Township Oneida Primary Registration District No. 5-230 Registered No. 13
City _____ (No. _____) St. _____ Ward _____
FULL NAME Mariane Danielle Still
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Date 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

4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant
MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
DATE OF BIRTH (MONTH, DAY AND YEAR) 10
AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 10
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 _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-11 1924
17. I HEREBY CERTIFY, That I attended deceased from May-1 1924, to May-11 1924, that I last saw her alive on May-11 1924 and that death occurred, on the date stated above, at 40 p.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cranial fracture
7 1/2 months
18. WHERE WAS DISEASE CONTRACTED? _____
IF NOT AT PLACE OF DEATH: _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) W. S. Bunnery, M. D.
, 19 (Address) Miller 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 Harvey point DATE OF BURIAL 5-18 1924
20. UNDERTAKER J. G. Morris ADDRESS Miller Mo

BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo
NAME OF FATHER Piley Still
BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo
MAIDEN NAME OF MOTHER Pearl Lamb
BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo
INFORMANT Piley Still (Address) _____
FILED July 24 1924 W. S. Bunnery REGISTRAR

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. S. NO. 2.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH
 County Linn Registration District No. _____
 Township W. 2nd Primary Registration District No. _____
 City _____ (No. _____) St. _____
 File No. _____
 Registered No. _____

2. FULL NAME Marian M. Stoll Ward _____
 (a) Residence, No. _____ St. _____
 (Usual place of abode) _____
 Length of residence in city or town where death occurred yrs. _____ mo. _____
 (If nomenclature give city or town and State) _____
 (If foreign birth) yrs. _____ mo. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE _____
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (For the word)
Mar.
 6. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE
 YEARS _____ MONTHS _____ DAYS _____
 IF LESS than 1 day, _____ hrs. _____ 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) Mos
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Pitney Stoll

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

12. MAIDEN NAME OF MOTHER Reedly Gault

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

14. INFORMANT Pitney Stoll
 (Address) _____

15. FILED _____ 19 _____
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) _____
 17. I HEREBY CERTIFY, That I attended deceased from _____
 that I last saw h. _____, 19____, to _____, 19____, at _____
 death occurred, on the date stated above, at _____
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

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) _____, 19____ (Address) _____

CONTRIBUTORY (SECONDARY) _____
 (duration) _____

 (duration) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____
 DATE OF BURIAL _____
 20. UNDERTAKER _____
 ADDRESS _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDE, HOMICIDE. (See reverse side for additional space.)

R. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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

1. PLACE OF DEATH

County Lawrence Registration District No. 469 File No.
 Township Lincoln Primary Registration District No. 5630 Registered No.
 City (No. St. Ward)

2. FULL NAME

Marion Daniel Steel
 (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 Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Don't know

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE 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)

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 7-1-24 W. S. Bruney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-11-1924

17. I HEREBY CERTIFY, That I attended deceased from to 19.....
 that I last saw him/her alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH?

DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

, 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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PLAINLY WITH UN... INK---THIS IS A PE... RECORD

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

SUPPLEMENTARY

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 neoplasm); *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.), "Dropsey," "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.