

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

17580

1. PLACE OF DEATH
 County Clark Registration District No. 193 File No. _____
 Township Des Moines Primary Registration District No. 5170 Registered No. _____
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME Mrs Lee Miller
 (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 (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8 1925

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 1 P. M.

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 30 1887

Myocardial Insufficiency

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>37</u>	<u>6</u>	<u>8</u>	

146
 (duration) 4 yrs. mos. ds.
 CONTRIBUTORY Infective female organs after child birth

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 _____

18. WHERE WAS DISEASE CONTRACTED

9. BIRTHPLACE (CITY OR TOWN) St. Francisville Mo
 (STATE OR COUNTRY)

IF NOT AT PLACE OF DEATH, _____

10. NAME OF FATHER Geo Brown

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER Mary Kline

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. O. Stroemder, M. D.
 19 (Address) St Francisville

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis Mo
 (STATE OR COUNTRY)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT Mrs Fred L Sloop
 (Address) Bryan Texas

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sand Cemetery DATE OF BURIAL 6-10 1925

15. FILED _____, 19____ REGISTRAR

20. UNDERTAKER H. F. Kircher ADDRESS Wayland

CAUSE OF DEATH in plain terms, so that it may be properly cared for. 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 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Mareasmus," "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.

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

1. PLACE OF DEATH

County Clark Registration District No. 193 File No. _____
 Township _____ Primary Registration District No. 5270 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Mrs. Lee Smith

(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

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lee Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 30 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
37 6 8

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House Wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Francisville MO
 (STATE OR COUNTRY)

10. NAME OF FATHER Lee Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Francisville MO
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Klein

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis MO
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Fred L. Sloop
 (Address) Bayan Texas

15. FILED June 9, 1925 H. F. Kuech
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8 1925

17. I HEREBY CERTIFY That I attended deceased from May 8 to June 8, 1925
 that I last saw him alive on May 8, 1925, and that death occurred, on the date stated above at 1 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Myo Cardial Insufficiency

CONTRIBUTORY Infected Renal organ
of child with

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) Ho Strosser, M. D.
 , 19 (Address) St. Francisville 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 Sand Cemetery DATE OF BURIAL 6-10 1925

20. UNDERTAKER H. F. Kuech ADDRESS Wayland

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THE STATE BOARD OF HEALTH BEING SO INFORMED BY THE REGISTRAR. PHYSICIANS SHOULD BE STATED EXACTLY. Exact statement of OCCUPATION required BY LAW.

SUPPLEMENTARY

