

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

Do not use this space.

29501

1. PLACE OF DEATH
 County Carroll Registration District No. 135
 Township _____ Primary Registration District No. 3010
 City Carrollton (No. 506) West Lincoln St. _____
 (If nonresident give city or town and State)
 2. FULL NAME Laura B. Connor
 (a) Residence. No. 506 West Lincoln St. 3rd Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No. _____
 Registered No. 72
 St. 3rd Ward

PERSONAL AND STATISTICAL PARTICULARS

*3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Connor
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-26-1872
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
53 8 15
 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

9. BIRTHPLACE (CITY OR TOWN) Carroll Co. Missouri
 (STATE OR COUNTRY)
 10. NAME OF FATHER Richard Hudson
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Eliya Hudson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
 (STATE OR COUNTRY)

14. INFORMANT Wm Hudson
 (Address) Carrollton, Mo
 15. FILED 10-12 1925 Mrs B E Larnham
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 10-11 1925
 17. I HEREBY CERTIFY, That I attended deceased from Aug 11, 1925, to Oct 11, 1925, that I last saw h. or alive on Oct 11, 1925, and that death occurred, on the date stated above, at 7:30pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

mitral cardiac disease
following an operation
for fibroid tumor
 CONTRIBUTORY (SECONDARY)
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED home
 IF NOT AT PLACE OF DEATH?
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Sept 28-25
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination confirmed by operation. W.H. Gartin M.D.
 (Signed) 10/12, 1925 (Address) Carrollton, 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 African Catholic DATE OF BURIAL 11/13 1925
 20. URBERTAKER Willie Bos ADDRESS Carrollton MO

PARENTS

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 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 may 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 Carroll Registration District No. 195- File No. _____
 Township _____ Primary Registration District No. 2010 Registered No. 72
 City Carrollton (No. _____) St. _____ Ward _____

2. FULL NAME

Laura B. Connor

(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 B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

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

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

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 10-1-22 1922 ms E B Farnham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-11 1922

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

metastatic Cardiac disease
following an operation
for fibroid tumor of
the uterus not malignant
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? 139 DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 _____ (Address)

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

20. UNDERTAKER _____ ADDRESS _____

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