

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

1 PLACE OF DEATH

County Osage
Township Osage
or
Village Barnots Mill
or
City (NO. _____) (St. _____) (Ward _____)

Registration District No. 1135 File No. 9176
Primary Registration District No. 5853a Registered No. 61

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Celestine Parry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 MARRIAGE STATUS Widowed
(Write the word)

6 DATE OF BIRTH November 21, 1874
(Month) (Day) (Year)

7 AGE 83 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Baton Rouge, La.

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) France
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) France

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Victor Parry
(Address) Barnots Mill, Mo.

15 Filed Aug 10, 1927 W. B. Peters Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 5, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 3, 1927, to March 5, 1927, that I last saw her alive on March 4, 1927, and that death occurred, on the date stated above, at 5:30 p.m.
The CAUSE OF DEATH* was as follows:

Myocardial Regurgitation
Broken Compensation
(Duration) 10 yrs. 10 mos. 10 ds.
CONTRIBUTORY (Secondary) 10
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. Leslie Meade M. D.
March 7, 1927 (Address) Barnots Mill Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Cadet Creek Cem DATE OF BURIAL Mar. 7, 1927

20 UNDERTAKER M. Harting ADDRESS Barnots Mill.

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, peritonaeum*, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)

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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Orange Registration District No. 1193- File No. 5-1
 Township Linn Primary Registration District No. 3-853-a Registered No. 61
 City (No. _____) St. _____ Ward _____

2. FULL NAME

Celestine Party
 (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 Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Joe Party.
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 5 1840
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 87 — 2 —
 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) (STATE OR COUNTRY) France
 10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) France
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) France

14. INFORMANT Justine Party
 (Address) Bonnato Mill Mo.
 15. FILED Apr 10 1927 A. B. Peters REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 1927
 17. I HEREBY CERTIFY, That I attended deceased from Mar 5, 1927, to Mar 5, 1927, that I last saw h. s. alive on Mar 5, 1927, and that death occurred, on the date stated above, at 5:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Regurgitation
Broken Compensation
 CONTRIBUTORY D.K.
 (SECONDARY) (duration) yrs. mos. ds.

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) E. L. Meads M. D.
 , 19 (Address) Bonnato Mill 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cadet Creek Cem DATE OF BURIAL 3-7-1927
 20. UNDERTAKER M. Roatting ADDRESS Bonnato Mill Mo

PARENTS

SUPPLEMENTARY

S-9116 A