

STATE DEPARTMENT, WITH UNFADING INK--THIS IS A PERMANENT RECORD

DEC 28 1928

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.

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

Do not use this space.

37380

1. PLACE OF DEATH

County Racke
Township Wayfield
City..... (No..... St..... Ward)

Registration District No. 277
Primary Registration District No. 5610

File No.....
Registered No. 6

2. FULL NAME

Nelia Massey

(a) Residence. No..... St..... Ward.....
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

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

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 6 1910

7. AGE

YEARS MONTHS DAYS
18 8 8
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Charley Massey

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

12. MAIDEN NAME OF MOTHER Massey

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

14. INFORMANT Charley Massey
(Address) Stoutland Mo.

15. FILED Nov. 16, 1928 C. E. Carlton

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14, 1928

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to Nov. 14, 1928 that I last saw her alive on Nov. 12, 1928, and that death occurred, on the date stated above, at 6:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sarcoma in the groin
(duration) 1 yrs. mos. ds.

CONTRIBUTORY A Bruise
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED at place of death
NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. E. Carlton, M. D.
Nov. 14, 1928 (Address) Stoutland 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

Honey Canyon
20. UNDERTAKER Tracy Evans

DATE OF BURIAL

Nov. 15, 1928

ADDRESS

Stoutland Mo.

ed United States Standard Certificate of Death

by U. S. Census and American Public Health
Association.)

ment of Occupation.—Precise statement of
n is very important, so that the relative
ness of various pursuits can be known. The
applies to each and every person, irrespec-
e. For many occupations a single word or
he first line will be sufficient, e. g., *Farmer or
Physician, Compositor, Architect, Locomo-
ner, Civil Engineer, Stationary Fireman*, etc.
any cases, especially in industrial employ-
is necessary to know (a) the kind of work
(b) the nature of the business or industry,
fore an additional line is provided for the
ement; it should be used only when needed.
ples: (a) *Spinner*, (b) *Cotton mill*, (a) *Sales-
Grocery*, (a) *Foreman*, (b) *Automobile fac-
e material worked on* may form part of the
atement. Never return "Laborer," "Fore-
Manager," "Dealer," etc., without more
pécification, as *Day laborer, Farm laborer,
Coal mine*, etc. Women at home, who are
in the duties of the household only (not paid
pers who receive a definite salary), may be
as *Housewife, Housework* or *At home*, and
not gainfully employed, as *At school* or *At
Care* should be taken to report specifically
upations, of persons engaged in domestic
or wages, as *Servant, Cook, Housemaid*, etc.

If the occupation has been changed or given up on
account of the DISEASE CAUSING DEATH, state occu-
pation at beginning of illness. If retired from busi-
ness, that fact may be indicated thus: *Farmer (re-
tired, 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*; *Broncho-
pneumonia* ("Pneumonia," unqualified, is indefinite);
Tuberculosis of lungs, meninges, peritoneum, etc.,
Carcinoma, Sarcoma, etc., of (name ori-
gin; "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 in-
tercurrent) affection need not be stated unless im-
portant. Example: *Measles* (disease causing death),
29 ds.; *Bronchopneumonia* (secondary), 10 ds.
Never report mere symptoms or terminal conditions,
such as "Asthemia," "Anemia" (merely symptom-
atic), "Atrophy," "Collapse," "Coma," "Convul-
sions," "Debility" ("Congenital," "Senile," etc.),
"Dropsy," "Exhaustion," "Heart failure," "Hem-
orrhage," "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 rail-
way 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 undesir-
able 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, hemor-
rhage, 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.