

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

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

PLACE OF DEATH Barry
County Barry
Township Barry or Village Barry or City Barry (NO. 31 Registration District No. 31 File No. 35249)
Primary Registration District No. 4022 Registered No. 4022 (Sl. East Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Margaret Lynn

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE widow MARRIED widow WIDOWED widow OR DIVORCED widow (Write the word)

DATE OF BIRTH July 10, 1874
(Month) (Day) (Year)

AGE 87 yrs. 4 mos. 20 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0

BIRTHPLACE (City or town, State or foreign country) Iowa

PARENTS

NAME OF FATHER Walters

BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa

MAIDEN NAME OF MOTHER Walters

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 20, 1912
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Oct 17, 1912, to Oct 20, 1912, that I last saw her alive on Oct 20, 1912, and that death occurred, on the date stated above, at 80 m.

The CAUSE OF DEATH* was as follows:
Paralysis & Senility

Contributory (SECONDARY) 167 (Duration) 6 1/2 yrs. 0 mos. 0 ds.

(Signed) B. B. Kelly M. D.
Nov. 9, 1912 (Address) Barry, Mo.

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

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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Smith
(ADDRESS) Barry, Mo.

Filed Nov. 9, 1912 O. L. Ireland REGISTRAR

PLACE OF BURIAL OR REMOVAL Barry, Mo. DATE OF BURIAL Oct 21, 1912

UNDERTAKER H. Raines ADDRESS Barry

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*; *Rebber 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.)

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

PLACE OF DEATH
 County Barry
 Township Purdy
 or
 Village Purdy
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 31 File No. 16
 Primary Registration District No. 4022 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Margaret Lynn

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>wh.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>wid</u>
DATE OF BIRTH <u>July 10</u> , 19 <u>24</u> (Month) (Day) (Year)		
AGE <u>87</u> yrs. <u>4</u> mos. <u>20</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Iowa</u>		
PARENTS	NAME OF FATHER <u>Walter</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>not obtainable</u>	
	MAIDEN NAME OF MOTHER <u>not obtainable</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Iowa</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 20, 1922
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Oct 12, 1922, to Oct 20, 1922, that I last saw her alive on Oct 20, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Paralysis & senility
Paraplegia & Cerebral
Hemiparesis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) B. B. Kelley M. D.
Nov. 9 1922 (Address) Purdy Mo.

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

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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Smith
 (ADDRESS) Purdy Mo

Filed Nov. 9 1922 P. L. Fitzgerald
 REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Armbach Cem</u>	DATE OF BURIAL <u>Oct 21</u> 19 <u>22</u>
UNDERTAKER <u>H. Rains</u>	ADDRESS <u>Purdy</u>

Original file, date OCT 1922

All information called for must be written on this Supplementary Certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

ORIGINAL WITH CHANGING INK—THIS IS A PERMANENT RECORD

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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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*;

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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 carboic 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.)