

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

502

1. PLACE OF DEATH  
 County Liberty Mo Clay Registration District No. 201 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3012 Registered No. 4  
 City Liberty Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Angeline Waller  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) 82 5 6 (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 <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug. 10-1840</u>				
7. AGE	YEARS <u>82</u>	MONTHS <u>5</u>	DAYS <u>6</u>	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) <u>Liberty Mo.</u> (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER <u>Hammel Lewis</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER <u>Liza Blackburn</u>			
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY)				
14. INFORMANT <u>Bonnie Story</u> (Address)				
15. FILED <u>W. J. Wafflewoodson</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>Jan. 16 1923</u>	
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 10</u> , 19 <u>23</u> , to <u>Jan 16</u> , 19 <u>23</u> that I last saw h. <u>at</u> alive on <u>Jan 18</u> , 19 <u>23</u> , and that death occurred, on the date stated above, at <u>9 a. m.</u>	
THE CAUSE OF DEATH* WAS AS FOLLOWS: <u>Cerebral Apoplexy</u>	
(duration) _____ yrs. _____ mos. <u>4</u> ds.	
CONTRIBUTORY (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) <u>E. H. Waller</u> , M. D. , 19 _____ (Address) <u>Liberty Mo</u>	
*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 <u>Liberty Mo</u>	DATE OF BURIAL <u>1-18 1923</u>
20. UNDERTAKER <u>Church - Stephen &amp; Co</u>	ADDRESS <u>Liberty</u>

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.

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

# Revised United States Standard Certificate of Death

[Approved by  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, 8 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, peritoncum*, 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," "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 can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County Clay Registration District No. 201 File No. \_\_\_\_\_  
Township \_\_\_\_\_ Primary Registration District No. 3012 Registered No. 14  
City Liberty Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Angeline Waller  
(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 Female 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 1840

7. AGE YEARS MONTHS DAYS 74 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Wife  
(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) Unknown

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Unknown

14. INFORMANT (Address) \_\_\_\_\_

15. FILED W. J. Gordon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 1923

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

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) \_\_\_\_\_, M. D.  
, 19 (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

WRITING 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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSIC. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should state 4 important.

1. PLACE OF DEATH  
County..... Registration District No..... File No.....  
Township..... Primary Registration District No..... Registered No.....  
City..... (No.....) St..... Ward.....

2. FULL NAME  
(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.

PERSONAL AND STATISTICAL PARTICULARS  
3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (or) WIFE OF.....

502

6. DATE OF BIRTH (MONTH, DAY AND YEAR)  
7. AGE YEARS MONTHS DAYS II 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)..... REGISTRAR.....

15. FILED..... 19.....

MEDICAL CERTIFICATE OF DEATH  
16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from.....  
that I last saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....  
THE CAUSE OF DEATH WAS AS FOLLOWS:  
.....

CONTRIBUTORY (SECONDARY)  
..... (duration)..... yrs..... mos..... ds.  
..... (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH..... DATE OF.....  
DID AN OPERATION PRECEDE DEATH.....  
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed)....., M. D.  
....., 19..... (Address)

\*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..... DATE OF BURIAL..... 19.....

20. UNDERTAKER..... ADDRESS.....