

N. B.—Every item of information should be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be properly classified.

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

38710

JAN 24 1927

1. PLACE OF DEATH
 County Lewis Registration District No. 481 File No. 31
 Township Lewis Primary Registration District No. 4290 Registered No. 10
 City Lewisport (No. _____) St. _____ Ward _____

2. FULL NAME Bertie G. Vance
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 30 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22, 1879

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>47</u>	<u>4</u>	<u>5</u>	

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) Housewife
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lewis County
 (STATE OR COUNTRY) _____

10. NAME OF FATHER John Carson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lewis Co.
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Alma F. Delland

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

14. INFORMANT Mrs Alma F. Carson
 (Address) Lewisport, Mo.

15. FILED 12/28 1926 J. Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) _____ 19____

17. I HEREBY CERTIFY, That I attended deceased from January 1, 1926, to December 27, 1926, that I last saw him alive on December 27, 1926, and that death occurred, on the date stated above, at _____ P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Intestinal nephritis
12 1/2 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) arterio sclerosis
 (duration) 17 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory analysis
 (Signed) R. B. Schaefer, M. D.
12/28, 1926 (Address) Lewisport, 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 Lewisport, Mo. DATE OF BURIAL Dec 29 1926

20. UNDERTAKER James A. Coder ADDRESS Lewisport, Mo.

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, Compositor, 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

...); *Lobar pneumonia*; *Bronchopneumonia*, etc. "Pneumonia," unqualified, is indefinite); *Phthisis*, *Phthisis of lungs*, *meninges*, *peritoneum*, 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 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 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN IN THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lewis

Registration District No. 481

File No. 3

Township Leurstown

Primary Registration District No. 7290

Registered No. 10

City (No. Leurstown)

St. Mo. Ward

2. FULL NAME

(a) Residence. No. Bertie J. Dance St. Mo. Ward 10

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
Name of employer None

PLACE (CITY OR TOWN) None

STATE OR COUNTRY None

NAME OF FATHER None

BIRTHPLACE OF FATHER (CITY OR TOWN) None

(STATE OR COUNTRY) None

12. MAIDEN NAME OF MOTHER None

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) None

(STATE OR COUNTRY) None

14.

INFORMANT (Address) None

15.

FILED 79 19 17 J. C. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1926

17. I HEREBY CERTIFY that I attended deceased from July 29 1926 to July 29 1926, 1926, that I last saw him alive on July 29 1926, and that death occurred, on the date stated above, at Leurstown, Mo.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH None

DID AN OPERATION PRECEDE DEATH? DATE OF None

WAS THERE AN AUTOPSY? None

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) None, M. D.

, 19 26 (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

N. B.—Every item of information should be carefully supplied. Accuracy is essential. Physicians should state cause of death in proper clinical terms, so that it may be properly classified. OCCUPATION is very important. REGISTRARS SHOULD SIGN THIS SUPPLEMENTARY.

SUPPLEMENTARY

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