

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

1806

**1. PLACE OF DEATH**

County Macon Registration District No. 15.33 File No. \_\_\_\_\_  
Township Round Grove Primary Registration District No. 5231 Registered No. \_\_\_\_\_  
City Clarence (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mrs Daisy Ruth Willey  
(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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 2-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 10 22 — — —

**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) Missouri

PARENTS

10. NAME OF FATHER Syms Alvord

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (State or Country) New York

12. MAIDEN NAME OF MOTHER Foley Winfield

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (State or Country) Illinois

14. INFORMANT Mr George Willey  
(Address) Clarence Mo

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2 2 MEDICAL CERTIFICATE OF DEATH  
16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1923

17. I HEREBY CERTIFY, That I attended deceased from June 1920 to Jan 10 1923  
(that I last saw him alive on Jan 10 1923, and that death occurred, on the date stated above, at 5:30 a.m.)

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma of breast + metastasis

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? yes DATE OF June 1920

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? State Pathologist

(Signed) S. M. Hall, M. D.

, 19 (Address) Clarence 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 Clarence DATE OF BURIAL Jan 26 1923

20. UNDERTAKER E E Hopper ADDRESS Clarence 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*, *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*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "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 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.

## 1 PLACE OF DEATH

533  
5721DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

County

Macon

Township

Round Grove

Village

City

(No. \_\_\_\_\_)

St.; \_\_\_\_\_

Ward) \_\_\_\_\_

Registered No. \_\_\_\_\_

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

2 FULL NAME

Mrs Daisy Ruth Willey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(If state the word)

6 DATE OF BIRTH

March 2, 1877  
(Month) (Day) (Year)

7 AGE

45 yrs. 10 mos. 22 ds.

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min. ?

8 OCCUPATION

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

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

15

Filed

3-22 1923

1923

E. F. Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 24, 1923  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
(SECONDARY)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_

\* 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

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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