PLACE OF DEATH

County _Ray_

Township _Crooked River_   Registration District No. _740_   File No. _____

or Village _____   Primary Registration District No. _4442_   Registered No. _20_

or City _Hardin_, (NO. _____, _____ St.; _____ Ward)

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

FULL NAME _Joy Marie Moris_

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)
Female	_White_	

DATE OF BIRTH _Jan - 2 - 1906_
(Month) (Day) (Year)

AGE _8_ yrs. _____ mos. _1_ ds.   If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _At school_

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _Neosho, Mo._

PARENTS

NAME OF FATHER _James Moris_

BIRTHPLACE OF FATHER (City or town, State or foreign country) _Spencer Co. Ind._

MAIDEN NAME OF MOTHER _Elsie Haines_

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _Spencer Co. Ind._

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _A. C. Rust_

(ADDRESS) _Hardin, Mo._

Filed _Mar - 9 - 1914_   _H E McGhee M D_
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _Jan - 3 -, 1914_
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _Dec - 23 -, 1913_, to _Jan - 3 -, 1914_,

that I last saw h_er_ alive on _Jan - 3 -, 1914_;

and that death occurred, on the date stated above, at _6_ a. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) _____ yrs. _____ mos. _12_ ds.

Contributory _____
(SECONDARY)

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

(Signed) _H. E. McGhee,_ M. D.

Mar - 9 - 1914 (Address) _Hardin, 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 _____

PLACE OF BURIAL OR REMOVAL _Lovelock Cemetery, Hardin_   DATE OF BURIAL _Jan - 5 - 1914_

UNDERTAKER _____   ADDRESS _____

Revised United States Standard Certificate of Death

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, 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 *septichaemia*," "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.)

PLACE OF DEATH

County _Ray_

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

Township
or
Village _Hardin_
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. _740_

Primary Registration District No. _4442_   Registered No. _20_

File No. _____

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

FULL NAME _Joy Marie Moris_

PERSONAL AND STATISTICAL PARTICULARS

SEX _F_   COLOR OR RACE _W_   SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) _S_

DATE OF BIRTH _Satisfactory Information Supplied._ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.   If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _Satisfactory Information Supplied_

(ADDRESS) _____

Filed _Apr-30_, 191_4_   _H. E. Welker M. D._
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _Jan 3_, 191_4_
(Month) (Day) (Year)

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:

Satisfactory Information Supplied.

_____ (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.

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 _____

PLACE OF BURIAL OR REMOVAL   DATE OF BURIAL
Satisfactory Information Supplied. 191_
UNDERTAKER _C. O. Mansur & Son_   ADDRESS _Hardin, Mo._

Original file, date _MAR 1914_, 19___   All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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