

## BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH

STATE BOARD OF HEALTH

File No. \_\_\_\_\_

County \_\_\_\_\_

CERTIFICATE OF DEATH

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

Decent \_\_\_\_\_  
(Write name, not number)

Registration District No. \_\_\_\_\_

or  
Inc. Town  
or

Primary Registration Dist. No. \_\_\_\_\_

City \_\_\_\_\_

(No. Breunster Hospital St., \_\_\_\_\_ Ward)If death occurred  
in a hospital or in-  
stitution, give its  
NAME instead of  
street and number]2 FULL NAME Nettie Kinross(a) Residence No. 1208 Duval W. St., \_\_\_\_\_ Ward, \_\_\_\_\_Length of residence in city or town where death occurred 2 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

4 COLOR OR RACE

5 Single, married  
Married,  
Widowed,  
or Divorced (Write the word)Female Colored5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Clinton Kinross6 DATE OF BIRTH \_\_\_\_\_, 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE

IF LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.35 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or  
particular kind of work housekeeper(b) General nature of in-  
dustry, business, or estab-  
lishment in which em-  
ployed (or employer) at home  
(c) Name of employer9 BIRTHPLACE (city or town) Colony, Va.  
(State or country)10 NAME OF FATHER unk known11 BIRTHPLACE OF FATHER (City or  
(State or country) Town) unk known12 MAIDEN NAME OF MOTHER unk known13 BIRTHPLACE OF MOTHER (City or  
(State or country) Town) unk known14 Informant Clinton Kinross  
(Address) 1208 Duval W.15 Filed \_\_\_\_\_, 192 \_\_\_\_\_  
Form V. S. No. 4 Registrar.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day  
and year) 11/7 192217 I HEREBY CERTIFY, That I attended deceased from  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,

and that death occurred, on the date stated above, 12:40 p.m.

The CAUSE OF DEATH\* was as follows:

Post  
operative Shock  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ 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) \_\_\_\_\_, 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 addi-  
tional space.)19 Place of Burial, Cremation, or Removal  
memorial Date of Burial  
or Removal 11/12 192220 UNDERTAKER  
Holmes ADDRESS

MARGIN RESERVED FOR BINDING

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

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each,  
and the number of each, in order of birth, stated.

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, 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 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 "Asthonia," "Anemia" (merely symptomatic, "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drop-sy," "Exhaustion," "Heart failure," "Hemorrhage," "In-anition," "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.)

ALL CERTIFICATES MUST BE WRITTEN PLAINLY, WITH UNFADING BLACK INK.

INFORMANT'S SIGNATURE

Items 1 to 13, inclusive, must be made over the signature of the informant.

MEDICAL CERTIFICATE OF DEATH

Items 16 and 17 to be made over the signature of the physician or other person responsible for making this portion of the certificate.

UNDERTAKER'S SIGNATURE

All death certificates must be made over the signature of the Undertaker or person acting as such.

RUBBER STAMP SIGNATURES NOT PERMITTED

Informants, Physicians, Coroners, Undertakers and Registrars must not use rubber stamp signatures—death certificates will be permanently preserved, and to be of value for legal purposes—all signatures must be written with unfading black ink.

Handwritten notes: Rev 7 and part, Other relative, Sister, Daughter, Grandson