STATE OF FLORIDA

BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH — STATE BOARD OF HEALTH — File No.

County

CERTIFICATE OF DEATH

Registered No.

Precinct (Write name, not number) — Registration District No.

or Inc. Town — Primary Registration Dist. No. — arranged

or City (No. St.; Ward) — Dr Ward

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

2 FULL NAME Rosa King

(a) Residence. No. Fifteenth St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 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)
Femal	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE 30 yrs. mos. ds. IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housekeeper

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

(c) Name of employer

9 BIRTHPLACE (city or town) D. C.
(State or country)

10 NAME OF FATHER Johnny King

11 BIRTHPLACE OF FATHER (City or Town) D. C.
(State or country)

12 MAIDEN NAME OF MOTHER Isabell Jones

13 BIRTHPLACE OF MOTHER (City or Town) D. C.
(State or country)

14 Informant Estella King
(Address) Fifteenth St

15 Filed ..... 192.....

Form V. S. No. 4 — Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) 11/16 1922

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 9:00a m.

The CAUSE OF DEATH* was as follows:

Pelvic Cellulitis

.....(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 additional space.)

19 Place of Burial, Cremation, or Removal: Memorial

Date of Burial or Removal: 11/21 1922

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, 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. See instructions on back of certificate.

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.), "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.)

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.*