

UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH  
 County De Kalb  
 Township Dallas Registration District No. 263 File No. 33805  
 or  
 Village \_\_\_\_\_ Primary Registration District No. 5366 Registered No. 17  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME William Riley Clarke

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>Male</u>	COLOR OR RACE <u>Caucasian</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>March</u> (Month) <u>31</u> (Day) <u>1899</u> (Year)		
AGE <u>61</u> yrs. <u>7</u> mos. <u>21</u> ds.		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>farm work</u>		

**2 MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH  
November (Month) 27 (Day) 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 15, 1910, to Nov. 27, 1910, that I last saw him alive on Nov. 27, 1910, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:  
Hemorrhage from lungs  
23A  
23B

BIRTHPLACE  
(City or town, State or foreign country) Clinton Co. Mo.

PARENTS	NAME OF FATHER <u>Edward Clarke</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>
	MAIDEN NAME OF MOTHER <u>Elizabeth Roman</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Clinton Co. Mo.</u>

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

Contributory Tuberculosis  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John Clarke  
(ADDRESS) Maysville, Mo.

Signed) W. J. Clark M. D.  
Nov 25 1910 (Address) Maysville 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 \_\_\_\_\_

Filed \_\_\_\_\_ 191\_\_\_\_ REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Wood Cemetery</u>	DATE OF BURIAL <u>Nov 27</u> 19 <u>10</u>
UNDERTAKER <u>J. Edwards</u>	ADDRESS <u>Mayville</u>

# 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, peritonaeum*, etc., *Carcinoma*, *Sar-*

*coma*, 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 septicaemia," "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

Township

or

Village

or

City

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

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

File No.

Registered No.

FULL NAME

(NO.

St.

Ward)

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

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(If write the date)

DATE OF BIRTH

AGE

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)

NAME OF  
FATHERBIRTHPLACE  
OF FATHER  
(City or town, State or foreign country)MAIDEN NAME  
OF MOTHERBIRTHPLACE  
OF MOTHER  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory

(SECONDARY)

(Signed)

\*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

UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH INK, and carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state  
N. B.—Every form should be properly classified. Exact statement of OCCUPATION is very important.Retalt  
Dallas

MISSOURI STATE BOARD OF HEALTH

263  
5366

33805

17

William Arley Clarke

male Caucasian Married

March 31, 1849

61 yrs. 7 mos. 21 ds.

Farmer.  
farm work

Clinton Co., Mo.

Edward, black

Mo. City

Elizabeth Froman

Clinton Co., Mo.

John Clarke

Mayville, Mo.

Nov 23, 1910 E. R. Straugh

November 22, 1910

Nov. 13, 1910, to Nov. 22, 1910,  
Nov. 22, 1910,  
11:30 p.m.

Pneumonia from lungs

tuberculosis

H. J. Clark

Nov 23, 1910 Mayville, Mo.

(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence

Hoods Cemetery Nov. 24, 1910

J. Davis Mayville

All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

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