

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.

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

PLACE OF DEATH
County Dunklin
Township Cloy
or
Village Coruth
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 282 File No. 34270
Primary Registration District No. 5405-B Registered No. _____

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

FULL NAME Willie Dean Chailand

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH Jan. 28, 1908
(Month) (Day) (Year)

AGE 3 yrs. 8 mos. 1 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) X O 1250

BIRTHPLACE
(City or town, State or foreign country) Coruth and

PARENTS
NAME OF FATHER O.E. Chailand
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dunklin, Mo.
MAIDEN NAME OF MOTHER Myrtle Thomas
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lake Co, Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E. Chailand
(ADDRESS) Coruth and

Filed Oct 6, 1911 Brookston
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 29, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 13, 1911, to Sept. 27, 1911, that I last saw her alive on Sept 27, 1911, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
38 malnutrition
73B
1250

(Duration) yrs. mos. ds.
Coroner P. G. Tipton
(Duration) yrs. mos. ds.
(Signed) P. G. Tipton M. D.
(Address) Senath,

*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 Liberty DATE OF BURIAL 9/30, 1911
UNDERTAKER C. P. McDouil ADDRESS Senath, 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*, *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.)



I had treated this child
for different spells of
malaria and chills.

And she began with
chills and fever in the
beginning of the spell of
sickness she had when
she died. - I treated her
for more than a
month previous to Dr.
P. G. Tipton. She had
enlargement of spleen and
liver. and all the shiggish
symptoms of chronic malaria.
Jas. West
J. H. Protherton

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

The enclosed certificate is defective for the reason that the disease named frequently cover tuberculosis and other definite causes. Name the disease causing "*Atrophy,*" "*Debility,*" "*Decline,*" "*Exhaustion,*" "*Inanition*" or "*weakness.*" These are vague terms.

Please correct and return, together with this card, in the enclosed stamped envelope.

FRANK B. HILLER, M. D.,

State Registrar.

Over

PLACE OF DEATH

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

County DunklinTownship Clayor Caruth mo

Village _____

or _____

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 932

File No. _____

Primary Registration District No. 5405BRegistered No. 16

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

FULL NAME Willie Dean Chailland

PERSONAL AND STATISTICAL PARTICULARS

SEX F. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.DATE OF BIRTH 1 28, 1908
(Month) (Day) (Year)AGE 3 yrs. 8 mos. 1 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) Caruth Mo.NAME OF FATHER Oscar E. ChaillandBIRTHPLACE OF FATHER
(City or town, State or foreign country) Dunklin Co. Mo.MAIDEN NAME OF MOTHER Margie ThomasBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Lake Co. Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. E. Chailland(ADDRESS) Caruth Mo.Filed OCT 6th 1911 J. M. Proctor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 9-29, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Sept. 13, 1911, to Sept. 27, 1911, that I last saw her alive on ", 1911, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

malnutrition-
chronic malaria

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

Contributory (SECONDARY) _____

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

(Signed) P. L. Tipton M. D. Oct. 6 1911 (Address) Senath 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 Liberty Cem. DATE OF BURIAL 9/30 1911UNDERTAKER C. O. McDaniel ADDRESS Senath Mo.

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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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.)

34270