

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

PLACE OF DEATH

County Saline
Township Grand Pass
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 795 File No. 36589
Primary Registration District No. 6038 Registered No. _____

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

FULL NAME Joseph Clyde Jr.

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH Feb 7 1863
(Month) (Day) (Year)

AGE 68 yrs. 7 mos. 25 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Surveyor
(b) General nature of industry, business, or establishment in which employed (or employer) 100

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

PARENTS
NAME OF FATHER Hiram Clyde
BIRTHPLACE OF FATHER (City or town, State or foreign country) New Haven, Ct
MAIDEN NAME OF MOTHER Mary R. Katz
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Saline Mass.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Hazen
(ADDRESS) Armstrong Mo.

Filed Oct 3rd 1911 A. Putnam REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 2nd 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 30, 1911, to Oct 2, 1911, that I last saw he alive on Oct 2, 1911, and that death occurred, on the date stated above, at 9:30 a.m., The CAUSE OF DEATH* was as follows:

Pneumonia

109R
123D (Duration) yrs. mos. 2 ds.

Contributory Paresis of Intestines
(SECONDARY) (Duration) yrs. mos. 2 ds.

(Signed) G. C. Gore M. D.
(Address) Marshall 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 Salk Springs, Mo. DATE OF BURIAL Oct 3 1911

UNDERTAKER Wm. Walker ADDRESS Marshall Mo.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Saline
Township Grand Pass
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 7.95 File No. 96389
Primary Registration District No. 6038 Registered No. _____

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

FULL NAME

Joseph Clyde

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M. COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widower
(Write the word)
DATE OF BIRTH Feb. 7, 1843
(Month) (Day) (Year)
AGE 68 yrs. 7 mos. 25 ds.
If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

DATE OF DEATH Oct. 2nd, 1911
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Sept 30, 1911, to Oct. 2, 1911,
that I last saw him alive on _____, 1911,
and that death occurred, on the date stated above, at 9:30am.

The CAUSE OF DEATH* was as follows:
Pneumonia

BIRTHPLACE (City or town, State or foreign country) Ohio
PARENTS
NAME OF FATHER Uriam Clyde
BIRTHPLACE OF FATHER (City or town, State or foreign country) New Hampshire
MAIDEN NAME OF MOTHER Mary R. State
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Salem Mass

(Duration) _____ yrs. _____ mos. 2 ds.
Contributory Paresis of Intestines
(SECONDARY) (Duration) _____ yrs. _____ mos. 2 ds.
(Signed) A. G. Gore M. D.
Oct. 2, 1911 (Address) Marshall 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Hazen
(ADDRESS) Armstrong Mo.
Filed Oct 31, 1911 A. D. Brown
REGISTRAR

PLACE OF BURIAL OR REMOVAL Salk Springs Cem. DATE OF BURIAL Oct. 3, 1911
UNDERTAKER P. M. Walker ADDRESS Marshall 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*, *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*, *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 septicæmia," "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.)