

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 Henry
Township _____ or Village _____ or City Clinton Mo (NO. _____) St. _____ Ward _____
Registration District No. 350 File No. 35920
Primary Registration District No. 3018 Registered No. 91

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

FULL NAME Gladis May Madell

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE single MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH May 20, 1912
(Month) (Day) (Year)

AGE 5 yrs. 14 mos. 14 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS NAME OF FATHER Claude Madell

BIRTHPLACE OF FATHER (City or town, State or foreign country) Lyon Co, Louisiana

MAIDEN NAME OF MOTHER Maggie Bonson

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Clinton Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Claude Madell

(ADDRESS) Clinton Mo

Filed 11/3, 1912 Nth M. Shauclaud
R. R. R. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 3rd, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 1st, 1912 to Nov. 3rd, 1912
that I last saw him alive on Nov. 2nd, 1912
and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

1912 Meningitis vs
suppression of brain

Contributory 10/4 (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R. B. Ross M. D. (Address) Clinton 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 not at place of death?

usual residence

PLACE OF BURIAL OR REMOVAL Johnstown Mo DATE OF BURIAL 11/4, 1912

UNDERTAKER W. H. Jones ADDRESS Clinton 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

2	2	3	3
7	8	1	2

... line is provided for the latter statement; it is used only when needed. As examples: (a) *Farmer*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material on this line may form part of the second statement. The 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 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.)

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

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PLACE OF DEATH
 County St. Louis
 Township _____
 or _____
 Village Clinton
 or _____
 City _____ (NO. _____ St.; _____ Ward)

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

CERTIFICATE OF DEATH

Primary Registration District No. 350 File No. _____

 Primary Registration District No. 3018 Registered No. 91

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

FULL NAME Gladis May Waddell

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>F</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>S.</u>	DATE OF DEATH <u>Nov 3</u> , 191 <u>2</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>May 20</u> , 191 <u>2</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Oct</u> , 191 <u>2</u> , to <u>Nov 2</u> , 191 <u>2</u> , that I last saw h <u>l</u> alive on <u>Nov 2</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>50</u> m.		
AGE <u>5</u> yrs. <u>5</u> mos. <u>14</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>at home</u> <u>meningitis, inflammation of brain</u> <u>by auto-infection of lungs</u> <u>through the perforated</u> <u>_____</u> (Duration) _____ yrs. _____ mos. _____ ds.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer)			Contributory <u>Battle fed</u> (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Clinton Mo</u>			(Signed) <u>R. B. Brown</u> M. D. <u>June 28</u> 191 <u>2</u> (Address) <u>Clinton Mo</u>		
PARENTS	NAME OF FATHER <u>Claude Waddell</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kans.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	MAIDEN NAME OF MOTHER <u>Maggie Bourne</u>		Where was disease contracted If not at place of death? Former or usual residence _____		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>		PLACE OF BURIAL OR REMOVAL <u>Clinton Mo</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Claude Waddell</u> (ADDRESS) <u>Clinton Mo</u>			DATE OF BURIAL <u>11/4</u> , 191 <u>2</u>		
Filed <u>Jan 7</u> 191 <u>3</u> <u>W. H. Sims</u> REGISTRAR			UNDERTAKER <u>Mrs. W. H. Sims</u> ADDRESS <u>Clinton Mo</u>		

Revised United States Standard Certificate of Death

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

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