

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

PLACE OF DEATH

County Andrew
Township Hodaway
or
Village _____
or
City Savannah (NO. 202 West Main)

Registration District No. 13 File No. 25
Primary Registration District No. 4010 Registered No. 2
St. _____ Ward _____

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

FULL NAME Anita Ruth McCord

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH October 26, 1896
(Month) (Day) (Year)

AGE 17 yrs. 2 mos. 14 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 Peoria Illinois
(City or town, State or foreign country)

PARENTS
NAME OF FATHER H. A. McCord
BIRTHPLACE OF FATHER Reno Ill
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Annie E. Kerr
BIRTHPLACE OF MOTHER Carlinville Ill
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(informant) C. E. Stevenson
(ADDRESS) Savannah Mo

Filed Jan 11, 1914 Wm. Waters, M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 10th, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 29, 1913, to Jan 10, 1914
that I last saw her alive on Jan 10, 1914
and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* was as follows:
Pneumonia (Hypostatic)
73 A
73 B
11 13 (Duration) yrs. ____ mos. ____ ds.
Contributory Pulmonary Hemorrhage
(SECONDARY) (Duration) yrs. ____ mos. ____ ds.
(Signed) C. E. Stevenson M. D.
Jan 10, 1914 (Address) Savannah 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 Carlinville Ill DATE OF BURIAL Jan 12, 1914
UNDERTAKER Leah Mitchell ADDRESS Savannah Mo

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.

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, 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 "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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. ALL PHYSICIANS should state FULLY.

PLACE OF DEATH

County Andrew

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

Township _____

Registration District No. 13

File No. _____

Village _____

Primary Registration District No. 4010

Registered No. 2

City Savannah (NO. 202 West Main)

St.; _____ Ward _____

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

FULL NAME

Avita Ruth Mc Cord

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W. SINGLE S MARRIED _____ WIDOWED _____ OR DIVORCED _____ (Write the word)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
Jan 10, 1914
(Month) (Day) (Year)

DATE OF BIRTH Oct 26, 1894
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

AGE 17 yrs. _____ mos. 14 ds. IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH was as follows:

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

Pneumonia (Hypostatic)
Tuberculosis Lung

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

Contributory Pulmonary Hemorrhage
(SECONDARY) (Duration) yrs. _____ mos. 11 ds.
(Signed) O. Jefferson M. D.
710, 1914 (Address) Savannah Mo.

NAME OF FATHER W. A. Mc Cord

BIRTHPLACE OF FATHER (City or town, State or foreign country) Lebanon, Mo.

MAIDEN NAME OF MOTHER Gracie Lee

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

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 5 yrs. _____ mos. _____ ds. In the 5 State yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) G. E. Starnes

Where was disease contracted If not at place of death? _____
Former or usual residence Illinois

(ADDRESS) Savannah

PLACE OF BURIAL OR REMOVAL W. A. Mc Cord
UNDERTAKER W. Johnson DATE OF BURIAL Jan 26, 1914
ADDRESS Savannah

Filed 1/11, 1914 W. Johnson REGISTRAR

Revised United States Standard Certificate of Death

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

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