

PLACE OF DEATH

County GreeneTownship Walnut Grove

Village _____

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

4589

Registration District No. 325File No. 14Primary Registration District No. 5450

Registered No. _____

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female	COLOR OR RACE White	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
DATE OF BIRTH <u>Feb.</u> <u>23</u> , <u>1879</u> (Month) (Day) (Year)		
AGE <u>35</u> yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) Housework		
BIRTHPLACE (City or town, State or foreign country) Walnut Grove Mo.		
PARENTS	NAME OF FATHER Thomas R. Blankenship	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky	
	MAIDEN NAME OF MOTHER Mary Wilder	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. E. McClure(ADDRESS) Walnut GroveFiled Feb 18, 1914, L. E. McClure

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
February 15, 1914, 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from
September, 1913, to **February**, 1914,
that I last saw her alive on **Feb. 15th.**, 1914,
and that death occurred, on the date stated above, at **8.15 A.**
The CAUSE OF DEATH* was as follows:**Turberculoses**23A(Duration) ____ yrs. 5 mos. 15 ds.Contributory
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.(Signed) L. E. McClure M. D.
2/18, 1914 (Address) Walnut Grove 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
Greene Lawn Cem. DATE OF BURIAL
2/18/14, 1914UNDERTAKER
Gene A. Brim ADDRESS
Walnut Grove

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*, *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*, *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 "Asthemia," "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 heading "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

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

County Wm
Township Walnut Grm
or
Village
or
City (NO. _____ St.; _____ Ward)

Registration District No. 325 File No. _____
Primary Registration District No. 5450 Registered No. 14

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

FULL NAME

Maud Edwards

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) M

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

DATE OF BIRTH _____, 191____
(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 8:15 m.

AGE _____ yrs. _____ mos. _____ 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 _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Tuberculosis lungs
Swamp & Br...
(Duration) _____ yrs. 5 mos. 15 ds.

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) 7/18 1914 (Address) Walnut Grm M. D.

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

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

*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) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

Filed 7/18 1914 H. E. McClure REGISTRAR

UNDERTAKER Gene a Br... ADDRESS Walnut Grm

Supplementary Information Supplied

Information should be in plain form.

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Revised United States Standard Certificate of Death

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

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