

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

PLACE OF DEATH

County Jackson
Township New Storm
or
Village _____
or
City Rich Hill Mo. (NO. _____ St.; _____ Ward)

Registration District No. 53
Primary Registration District No. 5084

File No. _____
Registered No. 7390
12

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

FULL NAME Rudy J Todd

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>6</u> (Month) <u>22</u> (Day) <u>1904</u> (Year)		
AGE <u>9</u> yrs. <u>10</u> mos. <u>ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>School Pupil</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

DATE OF DEATH
Mar 22, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 7, 1914, to Mar 22, 1914, that I last saw her alive on Mar 22, 1914, and that death occurred, on the date stated above, at 130A m.

The CAUSE OF DEATH* was as follows:
Pneumonia
9
1076

BIRTHPLACE
(City or town, State or foreign country) Andrain Co Mo

PARENTS	NAME OF FATHER <u>Ben Todd</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>
	MAIDEN NAME OF MOTHER <u>Allie Lewis</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Whooping Cough
(SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) H W Lusley M. D.
Mar 23, 1914 (Address) Rich Hill 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) Ben Todd
(ADDRESS) Rich Hill Mo
Filed Mar 23 1914 J. Gaudy REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Green Lawn</u>	DATE OF BURIAL <u>Mar 23</u> 19 <u>14</u>
UNDERTAKER <u>E. Wheelburger</u>	ADDRESS <u>Rich Hill Mo</u>

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*, *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. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Bates
Township New Home
or
Village _____
or
City _____

Registration District No. 53 File No. _____
Primary Registration District No. 5084 Registered No. 12
St. _____ Ward _____

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

FULL NAME

Ruby L. Todd

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)

DATE OF DEATH May 22, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1914 to _____, 1914, that I last saw him alive on _____, 1914, and that death occurred, on the date stated above, at 1:30 p.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) _____

Pneumonia
Bronchis
191
Contributory Whooping Cough
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) W. D. Wesley M. D.
3/23 1914 (Address) Rock Hill

*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 _____ DATE OF BURIAL _____ 1914

UNDERTAKER _____ ADDRESS _____

Filed 3/23 W. D. Wesley REGISTRAR

Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.

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

(ADDRESS) _____

Revised United States Standard Certificate of Death

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

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7395