

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

PLACE OF DEATH,

County Madison

Township _____
or Village Mur La Motte
or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 540
Primary Registration District No. 6230

File No. 16661
Registered No. 14

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

FULL NAME Glenda Kennon

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Dec 17 1913
(Month) (Day) (Year)

AGE 4 yrs. 4 mos. 29 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 (City or town, State or foreign country) Mur La Motte Mo

NAME OF FATHER Elbert Kennon

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mur La Motte Mo

MAIDEN NAME OF MOTHER Grace Duncan

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mur La Motte Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno Duncan
(ADDRESS) Mur La Motte Mo

Filed 5/27 1914 J.H. Barron REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 27 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 27, 1914, to May 27, 1914, that I last saw her alive on May 27, 1914, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:
Cholera Infantum
119A 104
(Duration) _____ yrs. _____ mos. 1 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J.H. Barron M. D. 5/27 1914 (Address) Mur La Motte 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 St Francis Co Mo DATE OF BURIAL 5/28 1914

UNDERTAKER C. P. Thomas ADDRESS Fredricktown 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, meningis, 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 "*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 septichoemia*," "*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.)

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

PLACE OF DEATH: Madison
County

Township or Village or City: Mine La Motte

Registration District No. 540
Primary Registration District No. 6030

File No. 16661
Registered No. 14

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

FULL NAME

Glenda Kennon

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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

PARENTS: NAME OF FATHER: Elbert Kennon
BIRTHPLACE OF FATHER: _____
MAIDEN NAME OF MOTHER: _____
BIRTHPLACE OF MOTHER: _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant): Jno Duncan

(ADDRESS): Mine La Motte Mo

Filed: 5/27 1914 M H Baron REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May 27, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: _____

(Duration) _____ mos. _____ ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ ds.
(Signed) _____ M. D.
_____, 191____ (Address) _____

*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: _____ 191____

UNDERTAKER: _____ ADDRESS: _____

Supplementary Information Supplied

Supplementary Information Supplied

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