

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

934

20391

PLACE OF DEATH

County St. Genevieve
Township Union
or
Village Sprott
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 5025
Primary Registration District No. 534
6026

File No. _____
Registered No. 5

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

FULL NAME Frederick McClanahan

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>X</u> WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>May</u> <u>23</u> , 191 <u>4</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. <u>13</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Child (at Home)</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

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

PARENTS	NAME OF FATHER <u>illegitimate</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country)
	MAIDEN NAME OF MOTHER <u>Viora McClanahan</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>St. Francois Co. Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mahala Angela X McClanahan
(ADDRESS) Sprott Mo

Filed 6/6/14 1914 H. Morgansteeen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 5, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 23, 1914, to June 5, 1914, that I last saw him alive on June 5, 1914, and that death occurred, on the date stated above, at 10 P.m.
The CAUSE OF DEATH* was as follows:
Convulsions

130
158
(Duration) _____ yrs. _____ mos. 2 ds.

Contributory Inanition
(SECONDARY)
(Duration) _____ yrs. _____ mos. 13 ds.
(Signed) G. B. Perkins M. D.
June 6, 1914 (Address) Sprott 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 <u>Lewis Cemetery</u>	DATE OF BURIAL <u>6/6</u> , 191 <u>4</u>
UNDERTAKER <u>Neigh love</u>	ADDRESS <u>Sprott Mo</u>

N. B.—Every item of information should be carefully supplied. AGE shown on United States Census, and SEX and 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

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

Registration District No. 934 File No. _____
 Primary Registration District No. 6026 Registered No. _____

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

FULL NAME Fredrich McClanahan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

DATE OF BIRTH _____, 191____, to _____, 191____,
 (Month) (Day) (Year)

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

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min. _____ sec.

The CAUSE OF DEATH* was as follows:
Convulsions

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) _____

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

NAME OF FATHER _____

(Signed) E. B. Perber M. D.
 10/6/14 (Address) _____

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

MAIDEN NAME OF MOTHER _____

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

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

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

Where was disease contracted if not at place of death? _____

Form of usual residence _____

(ADDRESS) _____

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

Filed 6/24 1914 H. Morgan REGISTRAR

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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2051

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