

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

PLACE OF DEATH

Caldwell

County

Township ~~Braymer~~

Village Braymer,

City (NO. St. Ward)

Registration District No. 93

Primary Registration District No. 4055

File No. 21960

Registered No. 23

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

FULL NAME Ola M. Phelps

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH July 21, 1914
(Month) (Day) (Year)

DATE OF BIRTH May 11th., 1895
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 25, 1914, to July 21, 1914, that I last saw him alive on July 21, 1914

AGE 19 yrs. 2 mos. 10 ds. If LESS than 1 day, hrs. or min.?

and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:

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

Pneumonia with Pleurisy (non-fibrinous) 110 (Effusion)
1076 (Duration) yrs. 0, mos. 0 ds.

BIRTHPLACE (City or town, State or foreign country) MO.,

1204 Contributory Mucos-Celitis
(SECONDARY) (Duration) yrs. 7 mos. 0 ds.

NAME OF FATHER Bert S. Phelps

(Signed) Carlisle B. Wooley M. D.
July 21, 1914 (Address) Braymer Mo

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

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER Louisa Stauffer

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

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

Where was disease contracted If not at place of death?

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Former or (last) residence St. Louis
PLACE OF BURIAL OR REMOVAL Braymer Cemetery, DATE OF BURIAL July 21st, 1914

(Informant) Bert S. Phelps,

UNDERTAKER E. P. Michael, ADDRESS Braymer, Mo,

(ADDRESS) Braymer, Mo.,

Filed July 21, 1914 A. H. Schroeder REGISTRAR

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.)

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
Caldwell
County
Township
or
Village
or
City

Registration District No. *93*
File No.
Primary Registration District No. *4055*
Registered No. *23*
St.:
Ward)

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

FULL NAME *Ola M. Phelps*

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>M</i>	COLOR OF RACE <i>W.</i>	SINGLE MARRIED WIDOWER OR DIVORCED <i>Single</i> (Write the word)
DATE OF BIRTH <i>Satisfactory Information Supplied.</i>		
AGE <i>Satisfactory Information Supplied.</i>		
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	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *July 21 1914*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Satisfactory Information Supplied.* to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, *Satisfactory Information Supplied.* the CAUSE OF DEATH* was as follows:
Broncho-pneumonia with Pleurisy (serofibrinous effusion) (Duration) *9* yrs. *2* mos. *0* ds.
Contributory *Colitis* (SECONDARY) (Duration) *2* yrs. *2* mos. *0* ds.

(Signed) *Harold Wogben* (Address) *Braymer 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 _____

SUPPLEMENTARY INFORMATION SUPPLIED.

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

PLACE OF BURIAL OR REMOVAL <i>Satisfactory Information Supplied.</i>	DATE OF BURIAL _____ 191____
UNDERTAKER	ADDRESS

FILED *Aug 29 1914* *J. Schrock*
REGISTRAR

Revised United States Standard Certificate of Death

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

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