

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.

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

PLACE OF DEATH

County Polk
Township Cligona
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 1701
Primary Registration District No. 6292

File No. 23648
Registered No. 38

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

FULL NAME (Unnamed) Straud

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH July 26, 1914
(Month) (Day) (Year)

DATE OF BIRTH July 26, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

AGE 1 yrs. 1 mos. 1 ds. if LESS than 1 day, 1 hrs. or 3 min.?

that I last saw h deceased, 191____, and that death occurred, on the date stated above, at 11/9 m. 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) _____

Perinatal death

BIRTHPLACE (City or town, State or foreign country) Cligona Mo

1.59 (Duration) 151 yrs. _____ mos. _____ ds.

NAME OF FATHER Best Straud

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

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

(Signed) W. H. [unclear] M. D. July 26, 1914 (Address) _____

MAIDEN NAME OF MOTHER Ida Francis

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Fair Play Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) J. P. [unclear]

Former or usual residence _____

(ADDRESS) Cligona Mo

PLACE OF BURIAL OR REMOVAL Salina Cemetery DATE OF BURIAL July 26, 1914

Filed July 27, 1914 J. P. [unclear] REGISTRAR

UNDERTAKER J. P. [unclear] ADDRESS Cligona 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, 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, for 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 in ver- yportant.

PLACE OF DEATH

Polk
Clifcut

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

MISSOURI
BUREAU OF VITALS
CERTIFICATE OF DEATH

County _____ Registration District No. *701* File No. _____
Township _____ or _____ Primary Registration District No. *6292* Registered No. *31*
Village _____ or _____ City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME *Unnamed (Stroud)*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, _____, 191____
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, 1____
(Month) (Day) (Year)

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

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

The CAUSE OF DEATH* was as follows:
Premature Birth

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 _____ (Duration) _____ yrs _____ mos _____ ds.
None

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) _____

(Signed) *Mrs. Emma Gordon* _____, 191____ (Address) *Clifcut 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) _____

(ADDRESS) _____

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

Filed _____ 191____ *X J F Roberts* REGISTRAR

UNDERTAKER _____ ADDRESS _____

Original file, date *JUL 1914*. All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY
Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

23648

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