

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

1 PLACE OF DEATH

County Andrew

Township _____

or _____

Village _____

or _____

City Savannah Mo.

Registration District No. 13

File No. 34552

Primary Registration District No. 4010

Registered No. 49

(NO. Nicholas Sautourina Ward)

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

2 FULL NAME Eva Eldora Cropps

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Dec 19 1867
(Month) (Day) (Year)

7 AGE 47 yrs. 11 mos. ds. If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Farley Iowa

10 NAME OF FATHER John F. Schornover

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio W. Va.

12 MAIDEN NAME OF MOTHER Mary Sampson

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. M. Cropps
(Address) Farley Iowa

15 Filed Nov 20 1914 Wm. K. Kerr Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 20 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 26 1914 to Nov 20 1914, that I last saw her alive on Nov 20 1914

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial meningitis

15th (Duration) yrs. mos. ds.

CONTRIBUTORY injury to knee joint
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. K. Kerr M. D.

Nov 20 1914 (Address) Savannah Mo.

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

18 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 Farley Ia.
if not at place of death?

Former or usual residence Farley Ia.

19 PLACE OF BURIAL OR REMOVAL Farley Ia. DATE OF BURIAL Nov 20 1914

20 UNDERTAKER Chas. Mitchell ADDRESS Savannah Mo.

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*, *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 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
Andrew
County
Township
or
Village
City

Registration District No. *13*
Primary Registration District No. *4010*
File No.
Registered No. *49*

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

FULL NAME *Eva Elvora Cropp*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH *Nov. 20*, 191*4*
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 191*4*, to _____, 191*4*, that I last saw him _____ alive on _____, 191*4*, and that death occurred, on the date stated, at _____ m.

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

The CAUSE OF DEATH* was as follows
Acute Osteomyelitis

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

Injury caused by a fall
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE
(City or town, State or foreign country)

Contributory *Injury to knee joint*
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

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)

(Signed) *Wm. Bailey* M.D.
Nov 20, 191*4* (Address) *Savannah*

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

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

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

Filed *Nov 20 1914*
REGISTRAR

PLACE OF BURIAL OR REMOVAL
DATE OF BURIAL _____ 191*4*
UNDERTAKER
ADDRESS

SUPPLEMENTARY INFORMATION SUPPLIED

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Revised United States Standard Certificate of Death

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

34552

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