

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

PLACE OF DEATH

County Butler

Township Beverdam

Village \_\_\_\_\_

City \_\_\_\_\_

Registration District No. 87

Primary Registration District No. 5129

File No. 298

Registered No. 5

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME

Cordelia M. Hellimis

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married  
(If write the word)

DATE OF DEATH January 23, 1915  
(Month) (Day) (Year)

DATE OF BIRTH April 17, 1877  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 16, 1915, to Jan 23, 1915, that I last saw her alive on Jan 22, 1915

AGE 37 yrs 9 mos 6 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

and that death occurred, on the date stated above, at 7:30 a.m.

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

The CAUSE OF DEATH\* was as follows:  
Cerebro Spinal meningitis  
18 (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) Edinburgh Tenn

NAME OF FATHER William G. Ginter

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

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

(Signed) H. E. White M. D. (Address) Faridesting

MAIDEN NAME OF MOTHER M. M. Moxey

\*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) Nashville Tenn

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State  \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Informant) C. M. Hellimis

Where was disease contracted if not at place of death? \_\_\_\_\_

(ADDRESS) Kerens mo

Former or usual residence \_\_\_\_\_

Filed Jan 30, 1915 R. L. Turner REGISTRAR

PLACE OF BURIAL OR REMOVAL Cathy Cem. DATE OF BURIAL 1/24, 1915

UNDERTAKER Franks ADDRESS Baylor Bldg 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.

CAUTION: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

# 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 organ; "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 "Asthemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "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.)

WITH EMPLOYER (for employer's  
 purchase of certificate) or  
 (for purchase from employer)  
 Department, kind of work  
 (for description of occupation)  
 OCCUPATION

NAME OF DECEASED  
 SEX  
 DATE OF BIRTH  
 AGE  
 PLACE OF BIRTH  
 PLACE OF DEATH  
 OCCUPATION  
 STATE OF DECEASED  
 COUNTY OF DECEASED  
 HOUSEHOLD NUMBER  
 STREET NUMBER  
 STREET  
 CITY  
 COUNTY  
 STATE  
 ZIP CODE

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  
County Butte  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. 87 File No. \_\_\_\_\_  
Primary Registration District No. 5129 Registered No. 51  
St.: \_\_\_\_\_ Ward) \_\_\_\_\_

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

FULL NAME Cardela M Nellums

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>M</u> <i>(Write the word)</i>
DATE OF BIRTH _____ (Month) (Day) (Year)		
AGE _____ yrs. mos. 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) _____		
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 23 1915  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_  
Satisfactory information supplied \_\_\_\_\_, 1915, to \_\_\_\_\_, 1915,  
that I last saw h. alive on \_\_\_\_\_, 1915,  
and that death occurred, on the date stated above, at 7:23 a.m.  
The CAUSE OF DEATH\* was as follows:  
Cerebro Spinal Meningeal Epidemic  
\_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. E. White M. D.  
1/24 1915 (Address) Fairdealings No

\*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 \_\_\_\_\_

Satisfactory Information Supplied

SUPPLEMENTARY

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_  
Filed July 30 1915 R. L. Turner  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Patty Cemetery  
UNDER TAKER P. Thonks  
DATE OF BURIAL Supp 24 - 1915  
ADDRESS Poplar Bluff, Mo

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

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Original filed State  
Information called for must be written on this Supplementary Certificate