

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

1 PLACE OF DEATH

County Jasper
Township West City
Village West City
City West City

Registration District No. 417

File No. 13055

Primary Registration District No. 3021

Registered No. 64

(No. 618 N. Klevon St.; Ward)

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

2 FULL NAME

Noia E. McClurg

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH March 24 1899
(Month) (Day) (Year)

7 AGE 36 yrs. 15 mos. 15 ds.
If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) 150B

9 BIRTHPLACE (City or town, State or foreign country) Missouri

10 NAME OF FATHER J. G. Klavis

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

12 MAIDEN NAME OF MOTHER Symantia Taylor

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. G. Klavis
West City, Mo.
(Address)

15 Filed 4/9 1915 L. P. Chenoueth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 16 1915 to April 8 1915 that I last saw her alive on April 6 1915 and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:
Rheumatism
Glaucotomhosa + Salvator
150B
115B

CONTRIBUTORY (Secondary) 1/1 (Duration) yrs. mos. ds.

(Signed) B. A. Dumbauld M. D. 4/19 1915 (Address) West City 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 if not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Phillipsburg Mo. DATE OF BURIAL April 10 1915

20 UNDERTAKER West City Land Co ADDRESS West City

Every item of information should be carefully supplied. Cause of death should be stated 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.)

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

PLACE OF DEATH
 County Jasper
 Township _____
 or Village _____
 or City Webb City (NO. _____ St.; _____ Ward)

Registration District No. 417 File No. _____
 Primary Registration District No. 3021 Registered No. 64

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

FULL NAME Nora E. McClurg

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 _____, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911, that I last saw h. _____ alive on _____, 1911, and that death occurred, on the date stated above, at _____

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

The CAUSE OF DEATH* was as follows:
Pneumonia & Salactorrhoea & Salactorrhoea

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) _____

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed June 3 1915 J. C. Ohmsover REGISTRAR

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

(Signed) H. J. [Signature] (Address) Webb City, 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 _____ DATE OF BURIAL _____ 1915

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

CAUSE OF DEATH in plain terms, so that it may be stated by a CITY. is very imp. info.

Revised United States Standard Certificate of Death

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

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