

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

PLACE OF DEATH

County Stone  
Township Cass  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 648 File No. 18043  
Primary Registration District No. 6111 Registered No. 2

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

FULL NAME Sarah L. Cloud

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OF RACE White SINGLE MARRIED Married WIDOWER OR DIVORCED (Write the word)  
DATE OF BIRTH \_\_\_\_\_ 1877 (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
AGE 37 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work House Work  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

DATE OF DEATH 5 21 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 27, 1914, to May 21, 1914, that I last saw her alive on May 21, 1914, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH\* was as follows:  
Emphysema of Lungs  
23rd

BIRTHPLACE (City or town, State or foreign country) Stone Co. Mo.  
NAME OF FATHER Malice Price  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.  
MAIDEN NAME OF MOTHER Martha Price  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

(Duration) 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory (SECONDARY) \_\_\_\_\_  
(Signed) J. D. Jessup M. D.  
(Address) Hurley Mo.

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) Chas. Cloud  
(ADDRESS) Hurley Mo.  
Filed May 4 1915 J. E. Cox REGISTRAR

PLACE OF BURIAL OR REMOVAL ✓ DATE OF BURIAL \_\_\_\_\_ 1914  
UNDERTAKER ✓ ADDRESS \_\_\_\_\_

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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

1 PLACE OF DEATH

County Stone  
Township Cass  
Village  
City

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

CERTIFICATE OF DEATH  
Registration District No. 648 File No. 18043  
Primary Registration District No. 6111 Registered No. 2

2 FULL NAME Sarah L. Cloud (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward) ([If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u>
6 DATE OF BIRTH (Month) _____ (Day) _____ (Year) _____		
7 AGE mos. _____ ds. _____	If LESS than 1 day, hrs. _____ or min. _____	
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country)		
PARENTS	10 NAME OF FATHER	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	12 MAIDEN NAME OF MOTHER	
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21 1915  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 191\_\_\_\_, to \_\_\_\_\_ 191\_\_\_\_, that I last saw him \_\_\_\_\_ on \_\_\_\_\_ 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ p.m. The CAUSE OF DEATH\* was as follows:

\_\_\_\_\_

\_\_\_\_\_

CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) \_\_\_\_\_ M. D. (Address) \_\_\_\_\_ 191\_\_\_\_

\*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. \_\_\_\_\_ 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 Wright Chappel DATE OF BURIAL May 22 1915

20 UNDERTAKER None ADDRESS \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_ (Address) \_\_\_\_\_

15 Filed May 15 1915 Registrar \_\_\_\_\_

Original file, date MAY 1915

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY Satisfactory Information Supplied.

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