

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

PLACE OF DEATH  
County Pulaski  
Township Roubidoux Registration District No. 715 File No. 2966  
or  
Village \_\_\_\_\_ Primary Registration District No. 5744 Registered No. \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Mildred McClary

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)  
DATE OF BIRTH 8 16, 1915  
(Month) (Day) (Year)  
AGE 4 15  
yrs. 4 mos. 15 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) MO

NAME OF FATHER Chas. McClary

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

MAIDEN NAME OF MOTHER Martie Anderson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Chas. McClary  
(ADDRESS) Harmon

Filed 1-1 1916 - RC Fowler  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12 31, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 6-4-25, 191, to 12-31, 1915,  
that I last saw her alive on Dec. 29, 1915,  
and that death occurred, on the date stated above, at 4 m.  
The CAUSE OF DEATH\* was as follows:

126A  
Bronchitis  
(Duration) yrs. mos. 7 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) yrs. mos. ds.  
(Signed) RC Fowler M. D.  
1-1 1916 (Address) Harmon

\*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 Pairview DATE OF BURIAL 1-1 1916

UNDERTAKER Tom Davis ADDRESS Harmon

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

**PLACE OF DEATH**

County.....

Township.....

or

Village.....

or

City.....

Registration District No. ....

File No. ....

Primary Registration District No. ....

Registered No. ....

(NO

St.

Ward)

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX

COLOR OR RACE

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(If *ride* the word)

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

..... 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)

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

191

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH

(Month)

(Day)

191

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h..... alive on....., 191.....

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

The CAUSE OF DEATH\* was as follows:

(Duration)..... yrs. .... mos. .... ds.

Contributory

(SECONDARY)

(Duration)..... yrs. .... mos. .... ds.

(Signed)

(Address)

M.

\*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. 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

191

UNDERTAKER

ADDRESS

1 PLACE OF DEATH

County Pulaski  
Township or Village Roundout

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

Registration District No. 715 File No. ....

Primary Registration District No. 3944 Registered No. ....

City Mildred NO. .... St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mildred Mc Clarry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

6 DATE OF BIRTH (mas) colle... (Month) (Day) 1 (Year)

7 AGE (yrs. mos. ds.) If LESS than 1 day, hrs. or min.?

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

10 BIRTHPLACE (City or town, State or foreign country)

11 NAME OF FATHER

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

13 MAIDEN NAME OF MOTHER

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

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

16 Filed 12-31-1915 Registrar R. C. Howland

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-31-15 (Month) (Day) (Year)

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

The CAUSE OF DEATH\* was as follows: acute Bronchitis  
(Duration) 7 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) 8 yrs. 1 mos. 1 ds.  
(Signed) R. C. Howland M. D.  
Lawrence (Address)

\*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 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted if not at place of death? at home  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191...

20 UNDERTAKER ADDRESS

SUPPLEMENTARY

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, Composer, 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, peritonacum*, 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), 29ds.; *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 septichaemia," "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.)

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