

INDEXING—THIS IS A PERMANENT RECORD

N. B.—Every item of info. 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.

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

PLACE OF DEATH  
County St. Clair  
Township Speedwell or Village \_\_\_\_\_ or City \_\_\_\_\_  
Registration District No. 969 File No. 4 18983  
Primary Registration District No. 6015 Registered No. 1  
(NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
FULL NAME Thomas J. McLeod [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 18 58 - 1861  
(Month) (Day) (Year)

AGE 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) unimproved land 73A

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

PARENTS

10 NAME OF FATHER Joseph Meard

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

12 MAIDEN NAME OF MOTHER Galley Cole

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 9 1916  
(Month) (Day) (Year)

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 \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
No attending physician, that to be tuberculosis of lungs  
(Duration) yrs. mos. ds.

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

(Signed) \_\_\_\_\_ M. D.  
\_\_\_\_\_ 191\_\_\_\_ (Address)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Deborah McLeod  
(ADDRESS) Phillip mo

15 Filed May 10 1916 J. B. Gathright REGISTRAR

\*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 RESIDENCE)  
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 Union Point DATE OF BURIAL May 10 1916

UNDERTAKER W. A. Stephens ADDRESS Caldorado

Revised United States Standard Certificate  
**Certificate of Death**

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

1017  
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**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*

*"Typhoid pneumonia"; Lobar pneumonia; Broncho-pneumonia ("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;*

MISSOURI

PLACE OF DEATH

County.....  
 Township..... Registration District No. ....  
 or Village..... Primary Registration District No. ....  
 or City..... (NO. ....)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) .....	(Day) .....
AGE	..... yrs. .... mos. .... ds.	IF LESS than 1 day, ..... hrs. or ..... min.?
OCCUPATION	(Year) .....	
(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 .....

REGISTRAR

MEDICAL

DATE OF DEATH .....

I HEREBY CERTIFY  
 that I last saw him .....  
 and that death occurred .....  
 The CAUSE OF DEATH

Contributory  
 (SECONDARY)  
 (Signed) .....

\*State the Disease Causing  
 (1) Means of injury; and (2) will  
 LENGTH OF RESIDENCE  
 RECENT RESIDENTS  
 At place of death ..... yrs. .... mos.  
 Where was disease contracted  
 if not at place of death?  
 Former or usual residence .....

PLACE OF BURIAL OR REPOSE .....

UNDERTAKER .....

1 PLACE OF DEATH

St. Clair  
Speedwell

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

Registration District No. 769 File No.

Primary Registration District No. 6015 Registered No.

(NO. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
FULL NAME Thomas J. McCord

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

BIRTH (Month) (Day) (Year)

If LESS than 1 day, hrs. or min.?

ON profession, or kind of work

Nature of industry or establishment in which employed (or employer)

PLACE OF BIRTH (Country)

NAME OF FATHER

PLACE OF BIRTH OF FATHER (City or town, State or foreign country)

MOTHER'S NAME

PLACE OF BIRTH OF MOTHER (City or town, State or foreign country)

IS TRUE TO THE BEST OF MY KNOWLEDGE

Alva Kaff  
Tiffin Mo.

1916 J. S. Sachright Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) (Year) 5 7 9 6

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) (Year) 1916

that I last saw him alive on (Month) (Day) (Year) 1916

and that death occurred, on the date stated above, at (Month) (Day) (Year) 1916

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

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

(Signed) M. D. (Address) 1916

\*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 DATE OF BURIAL 1916

20 UNDERTAKER ADDRESS

SUPPLEMENTARY INFORMATION Supplied.

**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), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthemia," "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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