

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

1 PLACE OF DEATH

County Clack  
Township Lincoln  
or  
Village Medell  
or  
City (NO. St. Ward)

Registration District No. 190 File No. 30701  
Primary Registration District No. 5264 Registered No. 43

2 FULL NAME Edwin B. Woodward

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE Married  
MARRIED WIDOWED OR DIVORCED  
(Write the word)

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

7 AGE 86 yrs. 3 mos. 6 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE  
(City or town, State or foreign country) New York

PARENTS  
10 NAME OF FATHER Samuel Woodward  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) not known  
12 MAIDEN NAME OF MOTHER Mary Livingston  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Frank Otherton  
(Address) Medell Mo.

15 Sept 30 1916  
Filed J. R. Bridges Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 30 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1 1916 to Sept 15 1916  
that I last saw him alive on Sept 15 1916  
and that death occurred, on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH\* was as follows:  
Myocarditis  
930  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)  
P. A. Gualtieri  
(Duration) yrs. mos. ds.  
(Signed) P. A. Gualtieri M. D.  
30 1916 (Address) Cherokee 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 Ashton Cemetery DATE OF BURIAL Oct 3 1916

20 UNDERTAKER J. H. Hail ADDRESS Kahoka Mo.

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) *Foremān*, (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 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.)

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

1 PLACE OF DEATH  
County *Clark*  
Township *Lincoln*  
or  
Village  
or  
City

Registration District No. *190* File No.  
Primary Registration District No. *5264* Registered No. *43*  
St. Ward

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

2 FULL NAME

*Edwin B. Woodward*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *M.*  
(Write the word)

6 DATE OF BIRTH  
(Month) (Day) (Year)

7 AGE  
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)

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

15 Filed *Nov. 4* 191*6*  
Registrar *J. B. Bridgman*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
(Month) (Day) (Year) *9-30-16*

17 I HEREBY CERTIFY, that I attended deceased from  
191 to 191  
that (last seen alive) on *9-30-16*  
and that death occurred, on the date stated above, at *79* m.

THE CAUSE OF DEATH\* was as follows:  
*Myocarditis Chronic*  
(Duration) *79* yrs. mos. ds.

CONTRIBUTORY  
(Secondary)  
(Signed) *J. A. Seal* M. D.  
*9/30/16* (Address) *Kahoka Mo.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, the (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 *Oshton Cem.* DATE OF BURIAL *Oct. 3, 1916*  
20 UNDERTAKER *J. H. Hoyle* ADDRESS *Kahoka Mo.*

Original file, date *SEP 30 1916*

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

Every item of information should be stated EXACTLY. PHYSICIAN should state OCCUPATION is very important.

SUPPLEMENTARY INFORMATION Supplied.

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