

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.

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

1 PLACE OF DEATH  
County St. Francois  
Township St. Francois or Flat River Mo Registration District No. 774 File No. 32227  
Village Flat River Mo Primary Registration District No. 44661 Registered No. 108  
City (NO. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Gladis Peurose

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>Sept 2nd 1915</u> (Month) (Day) (Year)		
7 AGE <u>1 yrs. 15 ds.</u>		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Washington Co., Mo</u>		
PARENTS	10 NAME OF FATHER <u>Fred Peurose</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	12 MAIDEN NAME OF MOTHER <u>Syble Dickey</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Fred Peurose  
(Address) St. Francois

15 Filed 191 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 17 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 16 1916 to Sept 17 1916 that I last saw her alive on Sept 16 1916 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:  
Tuberculosis of intestines  
25  
31  
(Duration) about 1 yrs. X mos. X ds.

CONTRIBUTORY Measles  
(Secondary) (Duration) about 2 mos. X ds.

(Signed) Edw. C. Rohrbach M. D.  
Sept 17 1916 (Address) Flat River 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 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.  
Where was disease contracted if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL R of P St. Francois DATE OF BURIAL 9/18/16  
20 UNDERTAKER J. H. English ADDRESS Flat River Mo

# 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.)

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE  
A FEE FOR CERTIFICATES UNTIL THEY  
ARE COMPLETED AS PRESCRIBED BY  
LAW1 PLACE OF DEATH  
St. Francois  
CountyTownship  
or  
Village  
or  
City  
Flat River

Registration District No. 774 File No.

Primary Registration District No. 4465 Registered No. 108

(NO. St. Ward.)

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

2 FULL NAME

Gladis Penrose

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W. 5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)6 DATE OF BIRTH  
(Month) (Day) (Year)7 AGE  
If LESS than  
1 day..... hrs.  
or..... min.?  
yrs. mos. ds.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 Sept 17, 1916 10:15 Tappin Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9-17-16  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from  
191..... to..... 191.....  
that I last saw him..... alive on..... 191.....  
and that death occurred, on the date stated above, at..... m.  
The CAUSE OF DEATH\* was as follows: Supplied.CONTRIBUTORY  
(Secondary)  
(Duration)..... yrs..... mos..... ds.  
(Signed)..... M. D.  
..... 191..... (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..... 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  
..... 191.....

20 UNDERTAKER ADDRESS

Original file, date SEP 1916, 19.....

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

# Revised United States Standard Certificate of Death

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

72227

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