

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

PLACE OF DEATH

County Jefferson  
Township Rock  
or  
Village  
or  
City

Registration District No. 423 File No. 19039  
Primary Registration District No. 5578 Registered No. 24  
St. Ward

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

FULL NAME Margaret A McClain

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED <i>(Write the word)</i>
DATE OF BIRTH <u>June 13, 1864</u> (Month) (Day) (Year)		
AGE <u>52 yrs. 11 mos. 15 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Jefferson Co Mo</u>		
NAME OF FATHER <u>John Sample</u>		
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>		
MAIDEN NAME OF MOTHER <u>Ann Hunt</u>		
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Maryland</u>		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>May 28<sup>th</sup></u> , 1917 (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>May 27<sup>th</sup></u> , 1917, to <u>May 28<sup>th</sup></u> , 1917, that I last saw her alive on <u>May 27<sup>th</sup></u> , 1917, and that death occurred, on the date stated above, at <u>10A</u> m.	
The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u> <u>83 A</u>	
(Duration) ___ yrs. ___ mos. <u>1</u> ds.	
Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.	
(Signed) <u>E. M. Seering</u> M. D. <u>May 28, 1917</u> (Address) <u>St. James and 9th</u>	
*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 <u>Richardson Cemetery</u>	DATE OF BURIAL <u>May 30, 1917</u>
UNDERTAKER <u>John Koch</u>	ADDRESS <u>Beaton Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Edward J McClain  
Kennedwick Mo  
(ADDRESS)  
Filed May 30, 1917 H J F Kirk  
REGISTRAR

**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.)

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CERTIFICATE OF DEATH

PLACE OF DEATH  
 County Jefferson  
 Township Rock  
 or  
 Village  
 City (NO. St. Ward)

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

Registration District No. 423 File No.  
 Primary Registration District No. 5578 Registered No. 24

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

FULL NAME Margaret A. McElaine

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) (Year) 1

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 May 30 1917 H. J. Kirk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) (Year) 191 to (Month) (Day) (Year) 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:  
Cerebral Hemorrhage  
Arterio-sclerosis  
 Duration..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Duration..... yrs..... mos..... ds.  
 (Signed) G. W. Seoung M. D.  
May 28 1917 (Address) Neumours, Mo.

\*Specify 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

# Revised United States Standard Certificate of Death

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

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19069  
*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 "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.)