

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

32668

1 PLACE OF DEATH

County Oregon

Township Koshkonoque, Mo
or Village Koshkonoque, Mo
or City

Registration District No. 631
Primary Registration District No. 4381

File No. 10
Registered No. 10

City (NO. St. Ward)

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

2 FULL NAME

Maud - Snodgrass

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Sept 5 1917
(Month) (Day) (Year)

6 DATE OF BIRTH February 27 1894
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 21 1917 to Sept 5 1917 that I last saw her alive on Sept 3 1917 and that death occurred, on the date stated above, at 12:55 PM

7 AGE 23 6 8 IF LESS than 1 day.....hrs. or.....min.?
.....yrs.....mos.....ds.

The CAUSE OF DEATH* was as follows:

Typhoid fever

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

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

9 BIRTHPLACE (City or town, State or foreign country) Missouri

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

10 NAME OF FATHER Clint Burkitt

(Signed) H.C. Shuttle M.D.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Richland Rock, Mo

Sept 6 1917 (Address) West Plains, Mo

12 MAIDEN NAME OF MOTHER Mary Ann Haywood

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

(Informant) Mrs Mary J. Haywood
(Address) Thayer, Mo

Where was disease contracted if not at place of death?

15 Filed Sept 5 1917 W.C. Amerman Registrar

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Koshkonoque Cemetery DATE OF BURIAL Sept 5 1917

20 UNDERTAKER Charles Gettings ADDRESS Thayer, Mo

N. B.—Every item of information should be accurately supplied. Every statement of OCCUPATION is very important. 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) *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 "Asthma," "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.)

County Oregon Registration District No. 631 File No. _____
Township _____ or _____ Primary Registration District No. 4381 Registered No. 10
Village _____ or _____ City _____ (NO _____ St. _____ Ward _____)

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

2 FULL NAME Maud Snodgrass

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE _____ yrs. _____ mos. _____ ds. 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 Sept 5 7 1917 W. C. Ameringer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 5 7 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 1917 to _____ 1917, that I last saw h. _____ on _____ 1917, 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) _____ M. D. _____ 1917 (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 Koshkonong Cemetery DATE OF BURIAL Sept 5 7 1917

20 UNDERTAKER Charles Boetting ADDRESS Thayer, Mo.

Satisfactory Information Supplied

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CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is necessary.

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Association]

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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.)

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