

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

1 PLACE OF DEATH

County Oass
Township Austin
or
Village
or
City (NO. St. Ward)

Registration District No. 147 File No. 37791

Primary Registration District No. 5210 Registered No. 31

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

2 FULL NAME Maggie Maline Dade

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX F 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(If write the word)

16 DATE OF DEATH Nov 24 1917
(Month) (Day) (Year)

6 DATE OF BIRTH June 22 1987
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 1 1917, to Nov 24 1917, that I last saw her alive on Nov 23 1917, and that death occurred, on the date stated above, at 8 a.m.

7 AGE 30 yrs. 5 mos. 2 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:
Typhoid fever
01
(Duration) 01 yrs. 01 mos. 01 ds.

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

CONTRIBUTORY (Secondary) (Duration) 01 yrs. 01 mos. 24 ds.
(Signed) E. E. Phelan M. D.
Nov 24 1917 (Address) Adrian Ind

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

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

10 NAME OF FATHER Pie McComie

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death 01 yrs. 01 mos. 01 ds. In the State 01 yrs. 01 mos. 01 ds.
Where was disease contracted if not at place of death?
Former or usual residence

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

19 PLACE OF BURIAL OR REMOVAL Austin Cemetery DATE OF BURIAL 11-25-1917

12 MAIDEN NAME OF MOTHER Anna Shaffer

20 UNDERTAKER H J Carr ADDRESS Adrian Mo

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J J Dade
(Address) Adrian Mo

15 Filed Nov 25 1917 G. B. G. Ford Registrar

CHECK 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.

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), *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.)