

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

1 PLACE OF DEATH

County Pack  
Township Maaney  
or  
Village  
or  
City (NO. St. Ward)

Registration District No. 710 File No. 39126  
Primary Registration District No. 5939 Registered No. 19

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

2 FULL NAME Yala Blanch Dadd

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Nov 29 1917  
(Month) (Day) (Year)

6 DATE OF BIRTH April 4 1901  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Nov 6 1917 to Nov 28 1917  
that I last saw her alive on Nov 28 1917  
and that death occurred, on the date stated above, at 12:30 a.m.

7 AGE 16 yrs 8 mos 25 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH\* was as follows:  
Typhoid fever  
1 01  
(Duration) yrs. mos. ds.

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.  
(Signed) E. Albright M. D.  
1917 (Address) Pleasant Hope Mo

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

PARENTS 10 NAME OF FATHER Charles Albert Dadd  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Pleasant Hope Mo  
12 MAIDEN NAME OF MOTHER Lillian Oglesby  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

\*State the Disease Causing Death, or, in death 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.

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

19 PLACE OF BURIAL OR REMOVAL Pleasant Hope Mo DATE OF BURIAL Nov 30 1917  
20 UNDERTAKER W J Prater ADDRESS Pleasant Hope Mo

15 Filed Nov 30 1917 Claude A Slagle  
Registrar

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, 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.)

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## CERTIFICATE OF DEATH

## 1 PLACE OF DEATH

County

polk.

Township

Mooney

or

Village

or

City

(NO.

St.

Ward)

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

Registration District No.

710

File No.

Primary Registration District No.

5-939

Registered No.

19

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

## 2 FULL NAME

G. Ola Blanch Dodd.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

f.

4 COLOR OR RACE

W.

5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

S.

6 DATE OF BIRTH

(Month)

(Day)

I. (Year)

7 AGE

yrs. mos. da.

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  
FATHER11 BIRTHPLACE  
OF FATHER

(City or town, State or foreign country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. E. H. Rymess

(Address)

Van Mo

15

Filed

Nov 30 1917

Clair H. Slagle

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov

29

1917

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

..... 191..... to..... 191.....

that I last saw h..... alive on..... 191.....

and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

(Duration)..... yrs..... mos..... da.

(Duration)..... yrs..... mos..... da.

(Signed).....

M. D.

191..... (Address).....

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or Recent Residents)At place  
of death..... yrs..... mos..... da. In the  
State..... yrs..... mos..... da.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....., 19.....

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

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