

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.

PLACE OF DEATH

County Ralls
Township Jasper
or
Village
or
City

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

Registration District No. 727 File No. 42377-1
Primary Registration District No. 5960 Registered No. 34
(No. St. Ward)

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

FULL NAME Joseph Fred Standefer

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH Nov. 20, 1917
(Month) (Day) (Year)

AGE 14 yrs. 14 mos. 14 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE
(City or town, State or foreign country) Ralls co Mo

PARENTS
NAME OF FATHER Fred Standefer
BIRTHPLACE OF FATHER Ill
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Myrtle Smith
BIRTHPLACE OF MOTHER Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C H Smith
(ADDRESS) Ladsonia

Filed Feb 5 1918 J. Walen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 4, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 3, 1917, to Dec 4, 1917, that I last saw him alive on Dec 4, 1917, and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

191 119
(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.
(Signed) W K McCall M. D.
Dec 3, 1917 (Address) Ladsonia

*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 Ladsonia DATE OF BURIAL 12-5-1917
UNDERTAKER None ADDRESS -

[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 the occupation may be known. The

gin; "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.

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

Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____
City _____ (NO. _____) _____
St. _____ Ward _____
(If death occurred hospital or institution give its NAME and its street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____		
AGE _____ yrs. _____ mos. _____ ds. _____ If less than 1 day, _____ hrs. _____ min. ?		

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

BIRTHPLACE
(City or town, State or foreign country) _____

NAME OF FATHER	BIRTHPLACE OF FATHER (City or town, State or foreign country)
MAIDEN NAME OF MOTHER	BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(ADDRESS) _____

Filed _____ 191____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased _____
_____, 191____, to _____, 191____,
that I last saw him alive on _____, 191____,
and that death occurred, on the date stated above, at _____
The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Duration) _____ yrs. _____ mos.
(Duration) _____ yrs. _____ mos.
(Signed) _____
(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS 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 _____ DATE OF BURIAL _____
UNDERTAKER _____ ADDRESS _____