

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Audrain

Township \_\_\_\_\_  
or \_\_\_\_\_

Village \_\_\_\_\_  
or \_\_\_\_\_

City Vandalia (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 91

Primary Registration District No. 4550

File No. 4136-A

Registered No. 6

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

2 FULL NAME May B Daniel

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Oct 16 1844  
(Month) (Day) (Year)

7 AGE 72 yrs. 3 mos. 25 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS  
10 NAME OF FATHER James H Fry  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky  
12 MAIDEN NAME OF MOTHER May Huff  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky See Supp.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) W P Daniel  
(Address) Vandalia, Mo

15 Filed 4/10 8 1918 Cottrell  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 11 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Supt 1918, at Feb 11 1918, that I last saw her alive on Feb 11 1918, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Stimash & Heart disease  
92 1/2  
95 1/2  
109  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. H. [Signature] M. D.  
711 1918 (Address) Vandalia, Mo

\*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 Vandalia Mo DATE OF BURIAL Feb 12, 1918

20 UNDERTAKER H. [Signature] ADDRESS Vandalia Mo

# 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 "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.)

1 PLACE OF DEATH

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

County Andrew

Township or Ward

Village or Wardalia

City (NO. 912 St. 912 Ward)

Registration District No. 912

File No. 6

Primary Registration District No. 4550

Registered No. 6

2 FULL NAME:

May. E. Samuel

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

PERSONAL AND STATISTICAL PARTICULARS:

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

6 DATE OF BIRTH: Oct 16 1943 (Month) (Day) (Year)

7 AGE: 3 25 yrs. mos. ds. If LESS than 1 day: hrs. or min.?

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

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

10 NAME OF FATHER: James Doy

11 BIRTHPLACE OF FATHER: Wardalia Mo

12 MAIDEN NAME OF MOTHER: Agnes Schubert

13 BIRTHPLACE OF MOTHER: Wardalia Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mr. Dove Nabin (Address) Wardalia Mo

15 Filed 191 Registrar W. Staus

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 11 1948 (Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Jan 20 to Feb 11 1918 and that I last saw him alive on Feb 11 1918 and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH was as follows: Stomach and Heart Mo. Acid Stomach

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents): 19 yrs. mos. ds. (Duration) 7 08 yrs. mos. ds.

CONTRIBUTOR (Secondary): Remains (Signed) W. Staus M. D. (Address) Wardalia Mo

\*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): 19 yrs. mos. ds. In the State 19 yrs. mos. ds.

At place of death: Wardalia Mo Where was disease contracted if not at place of death: Wardalia Mo Former or usual residences: Wardalia Mo

19 PLACE OF BURIAL OR REMOVAL: Wardalia Mo DATE OF BURIAL: Feb 13 1918

20 UNDERTAKER: W. Staus ADDRESS: Wardalia Mo

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4/35-A  
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), *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.)