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. WRITE PLAINLY, WITH UNFADING INK—

11809-a

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

PLACE OF DEATH

County: Stone
Township or Village or City: Union
Registration District No. 846
Primary Registration District No. 6110
File No. 11809-a
Registered No.
City (No. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Vedie Annie Ghau

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Female
COLOR OR RACE	white
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	single
DATE OF BIRTH (Month) (Day) (Year)	Feb 6, 1916
AGE	yrs. 1 mos. 18 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)	Mo
PARENTS: NAME OF FATHER	John P Ghau
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Mo
MAIDEN NAME OF MOTHER	Ethel Kimmons
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P Ghau
(Address) Clever Mo R#1

Filed Feb 8 1921 J P Jessup REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 24, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 18, 1918, to Mar 23, 1918, that I last saw her alive on Mar 23, 1918, and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:
Catarrhal Pneumonia
107A
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E E Wade M. D.
3/24 1918 (Address) Clever

*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	DATE OF BURIAL
Delewar Cemetery	3/24 1918
UNDERTAKER	ADDRESS
B.F. Nickles	Clever Mo

W... PLAINLY, WITH UNFADI... THIS IS A PERM... RECORD

Every ... formation should be carefully ... in plain terms, so that it may ...

PHYSICIANS should ...

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 *septichaemia,*" "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.)

HUGH STEPHENS, JEFFERSON CITY.

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

PLACE OF DEATH

County Howe

Township Lawrence

or Village

or City (NO. St.; Ward)

Registration District No. 846 File No. 17809-18

Primary Registration District No. 6110 Registered No.

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

FULL NAME Vedia Bernice Gann

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: 2 (Month) 6 (Day) 1918 (Year)

AGE: yrs. 0 mos. 15 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) Ind

PARENTS

NAME OF FATHER John P Gann

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

MAIDEN NAME OF MOTHER Ethel Kinnamond

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

SUPPLEMENT — SEE OTHER SIDE

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John P Gann

(ADDRESS) Elsberry Mo

Filed Feb 18 1921 J D Jessup REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mar 23 (Month) (Day) 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from March 18, 1918, to Mar 23, 1918, that I last saw her alive on March 23, 1918, and that death occurred, on the date stated above, at 1:00 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) C E Wade M. D.

191: (Address) Elsberry Mo

*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: Bellevue Cemetery DATE OF BURIAL: Mar 24 1918

UNDERTAKER: J F Nichols ADDRESS: Elsberry Mo

WRITE ... ING INK— ... ANENT

N. B.— ... item of in... applied. AGE s... be st... EXACTLY. PH... state
CAUSE OF DEATH ... properly classified. Exact statement of OCCUPATION is very important.

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

File No. 11809 C

PLACE OF DEATH

County Stone

Township Union Registration District No. 8446

or Primary Registration District No. 6110 Registered No. ______

Village ______

or

City ______ (No. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Hershel Reynolds

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX: Male. COLOR OR RACE: White. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single	DATE OF DEATH ______ (Month) ______ (Day) 191__ (Year)
DATE OF BIRTH: 12 (Month) 6 (Day) 1898 (Year)	I HEREBY CERTIFY, that I attended deceased from Jan 6, 1918, to Jan 18, 1918, that I last saw him alive on Jan 18, 1918, and that death occurred, on the date stated above, at ______ m.
AGE: 19 yrs. 1 mos. 8 ds. If LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis
OCCUPATION (a) Trade, profession, or particular kind of work: None	18 / 23 / 18 (Duration) ___ yrs. ___ mos. ___ ds.
(b) General nature of industry, business, or establishment in which employed (or employer) ______	Contributory (SECONDARY) ______ (Duration) ___ yrs. ___ mos. ___ ds.
BIRTHPLACE (City or town, State or foreign country): Mo	(Signed) E. E. Wade M. D.
PARENTS — NAME OF FATHER: J. C. Reynolds	191__ (Address) Galena Mo
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
MAIDEN NAME OF MOTHER: Leona Clark	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo	Where was disease contracted if not at place of death? ______
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Elmer Reynolds	Former or usual residence ______
(ADDRESS) Schoolgrove	PLACE OF BURIAL OR REMOVAL: Mt Carmel. DATE OF BURIAL: 1-15 1918
Filed Feb 4 191__ J. D. Jessup REGISTRAR	UNDERTAKER: B. F. Nichols. ADDRESS: Cassville Mo