

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

PLACE OF DEATH

County Henry  
Township Fairview  
or  
Village \_\_\_\_\_  
or  
City Shoepwater (NO. \_\_\_\_\_)

Registration District No. 351 File No. 23070  
Primary Registration District No. 2208 Registered No. 11  
549 V St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME

Clara Thurman

PERSONAL AND STATISTICAL PARTICULARS

SEX W COLOR OR RACE W SINGLE MARRIED married  
WIDOWED OR DIVORCED  
(Write the word)

DATE OF BIRTH July 6, 1865  
(Month) (Day) (Year)

AGE 53 yrs. 00 mos. 24 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

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

PARENTS NAME OF FATHER Olis Archer  
BIRTHPLACE OF FATHER (City or town, State or foreign country) All  
MAIDEN NAME OF MOTHER Jane Plum  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) All

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ch. Plummer  
(ADDRESS) Shoepwater

Filed Sept 10 1918 A. J. Finner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 30, 1918  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 21, 1918, to July 30, 1918, that I last saw her alive on July 30, 1918, and that death occurred, on the date stated above, at 4 a. m. The CAUSE OF DEATH\* was as follows:

Petanus

Contributory (SECONDARY) Infected Wound  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) Ch. Plummer M. D.  
71301 1918 Address Shoepwater

\*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 Leays Chapel DATE OF BURIAL 7/31 1918  
UNDERTAKER W. M. Conn ADDRESS Shoepwater Mo

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_, \_\_\_\_\_ St., \_\_\_\_\_ Ward)

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

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

OCCUPATION  
 (a) Trade, profession, or business, or establishment in which employed (or employer) \_\_\_\_\_  
 (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) \_\_\_\_\_, 191\_\_\_\_ (Year)

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 \_\_\_\_\_ in. The CAUSE OF DEATH\* was as follows:

Contributory  
 (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 \_\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*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. 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 \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

**1. PLACE OF DEATH**

County Henry Registration District No. 351 File No. \_\_\_\_\_  
 Township Harwood Primary Registration District No. \_\_\_\_\_ Registered No. 11  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Clara Hurman  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State.)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed; (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED July 19 \_\_\_\_\_

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 30 19 18

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Delirium caused from Auto Accident

CONTRIBUTORY (SECONDARY) Injured Wound (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. F. Howard M. D. , 19\_\_\_\_ (Address) Deerwater

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

SUPPLEMENTARY INFORMATION SHEET

REGISTRARS STAMP

# 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, Composer, 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

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