

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

1 PLACE OF DEATH

County Butler
Township Berry Dam
or
Village ✓
or
City ✓ (NO. St. Ward)

Registration District No. 87

File No. 32015a

Primary Registration District No. 5739

Registered No. 22

2 FULL NAME

Sarah E. Killredge

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>♀</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>widow</u>
6 DATE OF BIRTH <u>Dec 23</u> 18 <u>83</u> (Month) (Day) (Year)		
7 AGE <u>75</u> yrs. <u>10</u> mos. <u>5</u> ds.		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>at Home</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Marshall Mich</u>		
PARENTS	10 NAME OF FATHER <u>J Baedam</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Dont know</u>	
	12 MAIDEN NAME OF MOTHER <u>Dont know</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scotland</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 27 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct. 25 1918 to Oct 28 1918, that I last saw her alive on Oct 27 1918 and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:
Cerebral Congestion

(Duration)..... yrs..... mos. 7 ds.

CONTRIBUTORY (Secondary)
(Duration)..... yrs..... mos..... ds.

(Signed) Ann Davidson M. D.
Address Poplar Bluff 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

DATE OF BURIAL

Mable Hill

Oct 29 1918

20 UNDERTAKER

ADDRESS

Frank Hud. Co.

Poplar Bluff, Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Herby Killredge
Poplar Bluff Mo

15

Filed

11/8/18 1918 M. M. Raul
Registrar

Every item on this certificate is required by law. It is the duty of every physician, nurse, or other person who has charge of a patient, to report the death of such patient to the health officer of the community in which the death occurs. It is the duty of every person who has charge of a funeral home, to report the death of such person to the health officer of the community in which the death occurs. It is the duty of every person who has charge of a cemetery, to report the death of such person to the health officer of the community in which the death occurs. It is the duty of every person who has charge of a mortuary, to report the death of such person to the health officer of the community in which the death occurs. It is the duty of every person who has charge of a funeral home, to report the death of such person to the health officer of the community in which the death occurs. It is the duty of every person who has charge of a cemetery, to report the death of such person to the health officer of the community in which the death occurs. It is the duty of every person who has charge of a mortuary, to report the death of such person to the health officer of the community in which the death occurs.

PERMANENT RECORD

STATEMENT RECORD

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," "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.)

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

1. PLACE OF DEATH
 County Bates Registration District No. 87 File No. _____
 Township B. 200 Primary Registration District No. 5129 Registered No. 22
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Sarah E. Kettledge

(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>W</u>
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) _____		
PARENTS	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) _____	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 27 1918

17. I HEREBY CERTIFY That I attended deceased from Oct 27 1918 to Oct 27 1918 that I last saw her alive on Oct 27 1918, and that death occurred, on the date stated above, at near 6:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Congestion
10/10
 CONTRIBUTORY (SECONDARY) Influenza (duration) yrs. mos. ds. 4
 18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) W. M. Davidson, M. D.
Jan 20, 1919 (Address) Poplar Bluff, Mo.

*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 Marble Hill Cemetery DATE OF BURIAL Oct 29 1918

20. UNDERTAKER Frank Handstatter, Poplar Bluff, Mo. ADDRESS _____

14. INFORMANT _____ (Address) _____

15. FILED 11/8 1918 M. M. Luce REGISTRAR

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD

Information of a death should be reported to the health officer as soon as possible. Exact statement of OCCUPATION is very important. REGISTRARS SHALL LIVE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

32015A

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," "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.