

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

PLACE OF DEATH

County Oregon  
Township Princy  
or  
Village altan  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

636  
Registration District No. 636 File No. 34984  
5844 6884 5844  
Primary Registration District No. 6884 Registered No. 37

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

FULL NAME Clelia - Cooper

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 17, 1900  
(Month) (Day) (Year)

AGE 18 yrs. 2 mos. 11 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country) Wynona, Idaho

PARENTS  
NAME OF FATHER Tom Cooper  
BIRTHPLACE OF FATHER (City or town, State or foreign country) not known  
MAIDEN NAME OF MOTHER Mary Anderson  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dalen, MO

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Brawley  
(ADDRESS) altan

Filed Oct 18 1918 Ansich Bailey REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 18, 1918  
(Month) (Day) (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 \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Paralysis and fever  
the 3 months duration

86 D (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 66

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. 3 mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.  
5 \_\_\_\_\_, 191\_\_\_\_ (Address)

\*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 altan mo

PLACE OF BURIAL OR REMOVAL Hickory Grove DATE OF BURIAL Oct 18 1918

UNDERTAKER Neighbors ADDRESS altan

Mary Cooper Hays

## PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

(NO. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[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  
(Write the word)

DATE OF BIRTH

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

AGE

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ 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 from \_\_\_\_\_, 191 \_\_\_\_\_, to \_\_\_\_\_, 191 \_\_\_\_\_

that I last saw him alive on \_\_\_\_\_, 191 \_\_\_\_\_

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory

(SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_

: 191 \_\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Societal, 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 \_\_\_\_\_ 191 \_\_\_\_\_

UNDERTAKER

ADDRESS

this young lady takes Sarah in Kansas  
Her father is not know where she was brought  
Home. No Dr attended her and this is  
the information the people give where  
she died. the mother of her is gone and her  
address not know i don all i could  
to get it turned in but failed if i  
could get the address of her mother i  
would try to get it add

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

---

The enclosed certificate is defective for the reason that the precise form of Paralysis should be stated, as, *Acute Ascending Paralysis*; *Paralysis Agitans*, *Bulbar Paralysis*, etc. Write *General Paralysis of the Insane* in full. Distinguish *Paraplegia* and *Hemiplegia*, and in the latter, when sequel of Apoplexy or Cerebral Haemorrhage, *report the primary cause*.

Please correct, sign and return, together with this card.

585hE

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

1. PLACE OF DEATH  
 County Barren Registration District No. 636 File No. \_\_\_\_\_  
 Township Laney Primary Registration District No. 5844 Registered No. 37  
 City \_\_\_\_\_ (Not \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Orelia Cooper  
 (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 S  
(Usual the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (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 A. Brawley  
 (Address) Alton Mo

15. FILED Oct 17 1918 Ernoch Bailey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

15. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 4 1918

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:  
Senalysis 66

(duration) \_\_\_\_\_ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
 (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) No Physician M. D.  
 , 19\_\_\_\_ (Address)

\*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 new Liberty cemetery DATE OF BURIAL 10/6/1918  
 ADDRESS new Liberty, Mo

20. UNDERTAKER Neighborhood of Coffin

SUPPLEMENTARY

# 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

34984  
"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.