

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

PLACE OF DEATH

County Stone
Township Rogan
Village _____
or _____
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 843 File No. 43902
Primary Registration District No. 6085 Registered No. _____

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

FULL NAME

Goldie Threlfall

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Nov. 1, 1918
(Month) (Day) (Year)

DATE OF BIRTH Don't Know
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from She was, 1918, to A Holy Wellers, that I last saw h alive on, 1918 and had no physician and that death occurred, on the date stated above, at 8 P. M.

AGE 24 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Supposed Influenza and pneumonia

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

(Duration) _____ yrs. _____ mos. 5 ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____, 1918 (Address) _____

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

NAME OF FATHER Thomas Bond

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

MAIDEN NAME OF MOTHER Don't Know

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leroy V. Threlfall
(ADDRESS) Galena 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 _____

Filed 11/10 1918 Henson REGISTRAR

PLACE OF BURIAL OR REMOVAL Nolan Cemetery DATE OF BURIAL Nov 3 1918

UNDERTAKER Cozy Mue. Co. ADDRESS Galena Mo.

PLACE OF DEATH

County _____
 Township _____ File No. _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____) St. _____ Ward _____

Registration District No. _____
 Primary Registration District No. _____ Registered No. _____

**MISSOURI STATE BOARD OF HEALTH
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 CERTIFICATE OF DEATH**

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)
	DATE OF BIRTH	(Month) _____, 191____, to _____, 191____
AGE	_____ yrs. _____ mos. _____ ds.	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) _____

PARENTS

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 _____
 that I last saw him _____ alive on _____, 191____, to _____, 191____,
 and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:

_____ yrs. _____ mos. _____ ds.
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (SECONDARY)

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ M. D. _____ (Address) _____, 191____

*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 _____ In the _____
 Where was disease contracted if not at place of death? _____ yrs. _____ mos. _____ ds.
 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**

HT

OF DEATH

Registration District No. *843*

File No.

Primary Registration District No. *6685*

Registered No.

St.

Ward)

FULL NAME

Goldie Threlfall

(a) Residence No. St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Place 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

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

m

6. MARRIED, WIDOWED, OR DIVORCED

BY HUSBAND OR WIFE OF

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

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)

INFORMANT

(Address)

*L. V. Threlfall
Galena Mo.*

15.

FILED

11/31 1919 G. Benson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov 1 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:

CONTRIBUTORY (SECONDARY)

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) *L. V. Threlfall (not)*, M. D., 19 (Address) *Galena 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

DATE OF BURIAL

Nolan Cemetery

Nov. 3 1918

20. UNDERTAKER

ADDRESS

Craig Murr. Co.

Galena Mo.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Revised United States Standard Certificate of Death

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

43902

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.