

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

29310

1. PLACE OF DEATH  
 County Buchanan Registration District No. 80 File No. \_\_\_\_\_  
 Township Tremont, Primary Registration District No. 5720 Registered No. 30  
 City (No. 2 Miles S.E. of Garrettsburg, Mo. St. \_\_\_\_\_ Ward)

2. FULL NAME Pearl Tadlock,  
 (a) Residence. No. 2 M S.E. Garrettsburg, Mo. Ward. \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 33 yrs. mos. 3 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grafton T. Tadlock,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 18th. 1880.

7. AGE YEARS MONTHS DAYS IF LESS than day, hrs. or min.  
43 0 3

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housewife,  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Buchanan County,  
 (STATE OR COUNTRY) Missouri,

10. NAME OF FATHER Robert Lewis,

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

12. MAIDEN NAME OF MOTHER Elizabeth Marker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Buchanan Co.  
 (STATE OR COUNTRY) Missouri,

PARENTS

14. INFORMANT Grafton T. Tadlock  
 (Address) R.F.D.# 1, Frazier, Mo.

15. FILED 10/22 19 23 B.F. Dowell  
 REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 21st 1923  
 17. I HEREBY CERTIFY That I attended deceased from Oct 17th 1923 to Oct 21st 1923  
 that I last saw her alive on Oct 17th 1923 and that death occurred, on the date stated above, at 12:45 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Influenza Poliomylitis  
11B (duration) over 2 yrs. mos. da.  
 CONTRIBUTORY (SECONDARY) Poliomylitis 11B  
Influenza (duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH, St Joseph mo

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) B.F. Dowell, M. D. Address St Joseph mo  
10-22-1923

\*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 Blakeley Cemetery DATE OF BURIAL Oct. 23- 19 23.

20. UNDERTAKER Heaton-Beyeler and Co. ADDRESS St. Joseph, Mo.  
by J. H. Keele.

# Revised United States Standard Certificate of Death

(Approved by U. S. Consus 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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *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.

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

**1. PLACE OF DEATH**

County Buchanan  
Township Fremont  
City                      (No.                     )

Registration District No. 80  
Primary Registration District No. 5120

File No. 29310  
Registered No.                       
St.                      Ward                     

**2. FULL NAME** Pearl Tadlock

(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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21 19 23

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

17. I HEREBY CERTIFY, That I attended deceased from                      to                     , 1923, that I last saw h.                      live on                     , 1923, and that death occurred, on the date stated above, at                      m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 18-1880

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. X 30 0 3 X

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

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                     

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)                     , M. D.                     , 19                      (Address)

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

\*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.)

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)                     

19. PLACE OF BURIAL, CREMATION, OR REMOVAL                      DATE OF BURIAL                      19                       
20. UNDERTAKER                      ADDRESS                     

14. INFORMANT                      (Address)                     

15. FILED 11/22 19 23                      REGISTRAR                     

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

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