

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

9316

1929

1. PLACE OF DEATH

County Washington Registration District No. 1103 File No. 2
Township Johnson Primary Registration District No. 6186 Registered No. 4
City St. Charles (No. 61) St. _____ Ward _____

2. FULL NAME

Charles Edward Studdard

(a) Residence. No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
(Usual place of abode)

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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17 - 1919
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ___ hrs. or ___ min.
10 0 22

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

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

10. NAME OF FATHER Walter Henry Studdard

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

12. MAIDEN NAME OF MOTHER Mary May Miller

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

14. INFORMANT Walter Studdard
(Address) Sullivan Mo

15. FILED 3-11, 1929 Theo O Harmon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 8, 1929
17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1929 to Feb 8 1929
that I last saw him alive on Feb 8 1929, and that death occurred, on the date stated above, at 230 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Hemorrhage
Accidental injury (duration) yrs. mos. 20 0 0
CONTRIBUTORY (SECONDARY) fall while climbing trees (duration) yrs. mos. 0 0 0

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) Walter F. Mattox, M. D.
, 19 (Address) Sullivan 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 D.O.O.F. Sullivan Mo DATE OF BURIAL Feb 9 1929

20. UNDERTAKER T. P. Shaffer ADDRESS Sullivan Mo

Every item of information should be carefully supplied. AGE known by date of BIRTH. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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, 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

ples: (a) *Spinner*, (b) *Cotton mill*,
Grocery, (a) *Foreman*, (b) *Auto-*
material worked on may form
ond statement. Never return
an," "Manager," "Dealer," etc.,
ise specification, as *Day laborer*,
er—*Coal mine*, etc. Women at
aged in the duties of the house-
id *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 be-
ginning of illness. If retired from business, that
fact may be indicated thus: *Farmer (retired, 6*
yrs.). For persons who have no occupation what-
ever, 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*; *Broncho-*
pneumonia ("Pneumonia," unqualified, is indefinite);
Tuberculosis of lungs, meninges, peritoneum, etc.,
Carcinoma, Sarcoma, etc., of _____ (name ori-
gin; "Cancer" is less definite; avoid use of "Tumor"
for malignant neoplasm); *Measles, Whooping cough*,
Chronic valvular heart disease; Chronic interstitial
nephritis, etc. The contributory (secondary or in-
tercurrent) affection need not be stated unless im-
portant. Example: *Measles* (disease causing death),
29 ds.; *Broncho-pneumonia* (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," "In-
anition," "Marasmus," "Old age," "Shock," "Ure-
mia," "Weakness," etc., when a definite disease can
be ascertained as the ca
diseases resulting from chi
"PUERPERAL septicemia,"
etc. State cause for whic
undertaken. For VIOLENT
INJURY and qualify as A
HOMICIDAL, or as *probably*
termine definitely. Exam
ing; struck by railway train-
of head—homicide; Poisons
ably 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 unde-
sirable terms and refuse to accept certificates containing them.
This 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, hemor-
rhage, 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
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

931L

1. PLACE OF DEATH

County Washington Registration District No. 1103 File No. 931L
Township Johnson Primary Registration District No. 6186 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Charles Edward Studdard
(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 S
(Write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/18 1929

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

17. I HEREBY CERTIFY That I attended deceased from _____, 18____, 19____ that I last saw h. _____ alive on _____, 18____, and that death occurred, on the date stated above, at _____.

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

Cerebral hemorrhage
(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 _____

Accidental injury, fall while climbing in tree
(duration) _____ yrs. _____ mos. _____ ds.

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

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)

*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.

14. INFORMANT _____
(Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19 _____

15. FILED 2-11 1929 J. O. Harmon
REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

1853

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION
every item of information should be carefully supplied by stated authority.

S-9316