

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

Do not use this space.

35026  
 36000

1. PLACE OF DEATH

County Death  
 Township Moreland  
 City (No. ....) .....

Registration District No. 814  
 Primary Registration District No. 6063

File No. ....  
 Registered No. 9  
 St. .... Ward) .....

2. FULL NAME

Ira Mc Clendon

(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 Male 4. COLOR OR RACE Negro 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) Mar, 15, 1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
20 7 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none  
 (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) Ark.

10. NAME OF FATHER Frank Mc Clendon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Texas

12. MAIDEN NAME OF MOTHER Jess Little

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Texas

14. INFORMANT (Address) Mark Mc Calister  
Benton, Mo.

15. FILED Oct 30 1929 W. W. Brady  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 29, 1929

17. I HEREBY CERTIFY That I attended deceased from Oct. 29, 1929 to Oct. 29, 1929 that I last saw him live on 11 a. m. death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Syphilis

CONTRIBUTORY (SECONDARY) about 4 yrs. mos. ds.  
 (duration) .....

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) W. W. Brady M. D.  
 , 19 29 (Address) Benton, 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  
County farm land, Oct. 30 1929

20. UNDERTAKER  
C. D. M. Gupston Mo.

PARENTS

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., *Farmër 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*, (c) *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*; *Broncho-pneumonia* ("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 neoplasm); *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. be ascertained as to diseases resulting from \_\_\_\_\_ *RUERPERAL septicæ* etc. State cause for undertaken. For VI INJURY and qualify HOMICIDAL, or as, pro termine definitely. ing; struck by railway of head—homicide; ably suicide. The n of skull, and conse may be stated unde (Recommendations approved by Comn American Medical A

NOTE.—Individual of able terms and refuse t Thus the form in use in will be returned for add the following diseases, of death: Abortion, ce rhage, gangrene, gastrit necrosis, peritonitis, ph But general adoption of the minimum list suggested has brought about a vast improvement, and its scope can be extended at a later date.

J. W. S.

②  
J. W. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.