FILED MAY 12 1942

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

15727

1 PLACE OF DEATH

County: Saline

Township: Arrow Rock — Registration District No. 792 — File No.

or Village: Rural — Primary Registration District No. 4478 — Registered No. 5

or City: near Nelson No. ..... St.: ..... Ward)

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

2 FULL NAME: Edna Rhoina Trigg.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: 21 May (Month) (Day) 1926 (Year)

7 AGE: 15 yrs. 10 mos. 16 ds. — If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Blackwater Mo

PARENTS

10 NAME OF FATHER: James Freeman

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Blackwater Mo

12 MAIDEN NAME OF MOTHER: Corene Chace

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Blackwater Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Freeman

(Address) Robertson Mo

15 Filed Apr. 11, 1942 Mrs. W. E. Shackelford, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr (Month) 7 (Day) 1942 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 3, 1942, to Apr 7, 1942, that I last saw her alive on Apr 7, 1942, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia

108

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Influenza and Streptococci Sore throat

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

(Signed) R. W. Stoupfer M. D.

Apr 11, 1942 (Address) Nelson Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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: Blackwater Mo.

19 PLACE OF BURIAL OR REMOVAL: Sapington Sump Saline Co Mo

DATE OF BURIAL: Apr. 11, 1942

20 UNDERTAKER: F. D. Ferguson

ADDRESS: Marshall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

District Health Officer No. 8,

District File Number _____

Date Filed 5-11-42

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 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, peritonaeum*, 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*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "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.)

JAN 3 1949

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No..... Primary Registration District No..... Registrar's No.....

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)
In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME.....

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife.....
Oliver Alvin Trigg

6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years ..... Months ..... Days ..... If less than one day ..... hr. ..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Apr. 11. 1942 (Date received local registrar) (b) Mrs. W. E. Shackelford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....;
that I last saw h..... alive on..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death.....	
Due to.....	
Due to.....	
Other conditions..... (Include pregnancy within 3 months of death)	

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
..... (Specify type of place)
While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed _____

1942
S-15727