

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Henry

Township _____
or
Village _____
or
City Clinton (NO. 814 Auguste St., 1st Ward)

Registration District No. 330

File No. 34044

Primary Registration District No. 308

Registered No. 81

FULL NAME Stell Birth

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Girl COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(If wife the word)

DATE OF BIRTH 11 14, 1910
(Month) (Day) (Year)

AGE stee birth If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

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

PARENTS
NAME OF FATHER Orville J. Mason
BIRTHPLACE OF FATHER (City or town, State or foreign country) Paris Mo
MAIDEN NAME OF MOTHER Missie Wellions
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Benton Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Menees
(ADDRESS) Clinton Mo

Filed Nov 25 1910 J. M. Thauland
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11 14, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 11, 1910, to Nov 11, 1910, that I last saw him Nov 11, 1910, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:
Compression of cord.

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

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

(Signed) A. J. Menees M. D.
Nov 25 1910 (Address) Clinton 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 _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1910

UNDERTAKER _____ ADDRESS _____

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*, *Sar-*

coma, 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.)



BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF BIRTH

Henry

County

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

Registration District No. *330*

File No. *340244*

Township

Village

Clinton

Primary Registration District No. *2018*

Registered No. *81*

City

(No. *814 Augusta* St. *1st* Ward)

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

FULL NAME *Still Birth*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *Girl* COLOR OF RACE *White* SINGLE MARRIED WIDOWED OR DIVORCED (If All checked)

DATE OF DEATH *Nov 11 - 14, 1910*
(Month) (Day) (Year)

DATE OF BIRTH *11 14, 1910*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Nov. 11, 1910*, to *Nov. 14, 1910*, that I last saw him *on Nov 11, 1910*, and that death occurred, on the date stated above, at *3 a.m.* The CAUSE OF DEATH* was as follows:
Compression of cord.

AGE *Still birth* If LESS than 1 day, ___ hrs. ___ mos. ___ ds. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) *Clinton Mo*

PARENTS NAME OF FATHER *Walter J. Moad* BIRTHPLACE OF FATHER (City or town, State or foreign country) *Pittsburg, Mo* MAIDEN NAME OF MOTHER *Russie Williams* BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Penton Co. Mo*

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds. (Signed) *A. J. Moad* (Address) *Clinton Mo*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *A. J. Moad* (ADDRESS) *Clinton 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 *Nov 25, 1910* Registered *J. M. Shaulhan* REGISTRAR

PLACE OF BURIAL OR REMOVAL *Our Lady's Cemetery, Clinton, Mo* DATE OF BURIAL *Nov 14, 1910* UNDERTAKER *E. E. Spore* ADDRESS *Clinton, Mo*

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