

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

PLACE OF DEATH

County Shelby
Township Salt River
or
Village _____
or
City Shelbina (NO. _____ St. _____ Ward _____)

Registration District No. 830
Primary Registration District No. 6091

File No. _____
Registered No. 11

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

FULL NAME Carolyn Cleaver

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH January 14, 1915
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Shelbina, Mo.

PARENTS NAME OF FATHER Ben H. Cleaver BIRTHPLACE OF FATHER (City or town, State or foreign country) Perry, Mo. MAIDEN NAME OF MOTHER Mabel Lewis BIRTHPLACE OF MOTHER (City or town, State or foreign country) Canton, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ben H. Cleaver (ADDRESS) Shelbina, Mo.

Filed Feb 16, 1915 R. S. Battushy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 15, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 3rd, 1915, to Feb 15th, 1915, that I last saw her alive on Feb 14th, 1915, and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:
89A Meningitis
79A

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory Stitis media (SECONDARY) (Duration) _____ yrs. _____ mos. 7 ds.

(Signed) J. A. Harrison M. D. Feb 15, 1915 (Address) Shelbina, 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 Canton, Mo. DATE OF BURIAL Feb 16, 1915
UNDERTAKER E. Peter ADDRESS Shelbina, Mo.

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.

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, 8 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 "Asthena," "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 *septicaemia*," "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 carbonic 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.)

PLACE OF DEATH

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

County

Township

or

Village

or

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO.

St.:

Ward)

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

FULL NAME

Shelby Salt River
Carolyn Cleaver

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH

DATE OF BIRTH

AGE

IF LESS than 1 day, hrs. or min. yrs. mos. ds.

I HEREBY CERTIFY, that I attended deceased from

Satisfactory, 191*5*, to _____, 191____,

that I last saw h*im* alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

meningitis
176

Contributory (SECONDARY) *Stites media*

(Signed) *J. A. Turney* M. D.

2/16 191*5* (Address) *Shelbyville 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 _____ 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

UNDERTAKER

ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed *Feb 16* 191*5* *R.S. Battushy*

REGISTRAR

SUPPLEMENTARY

Exact statement of OCCUPA. is ver.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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