

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

PLACE OF DEATH  
County Callaway  
Township McCords  
or  
Village  
or  
City Fulton (NO. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)

Registration District No. 102 File No. 15445  
Primary Registration District No. 0707 Registered No. 77

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

FULL NAME Mrs. May Crawford

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

SEX Female COLOR OR RACE White  SINGLE  MARRIED  WIDOWED  OR-DIVORCED Hand  
(If Wife the word)

DATE OF DEATH May 20, 1915  
(Month) (Day) (Year)

DATE OF BIRTH Dec 8, 1868  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June, 1914, to May 20, 1915,  
that I last saw her alive on May 19, 1915,

AGE 47 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

and that death occurred, on the date stated above, at 12:45 a.m.  
The CAUSE OF DEATH\* was as follows:

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

Tuberculosis  
B3-A  
44-A

BIRTHPLACE (City or town, State or foreign country) Jackson Colorado

(Duration) one or more yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER J Henerson

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) New York

(Signed) [Signature] M. D. (Address) Fulton

MAIDEN NAME OF MOTHER May Henderson

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE (Informant) [Signature]

Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

(ADDRESS) Fulton Mo

PLACE OF BURIAL OR REMOVAL Fulton Mo DATE OF BURIAL May 21, 1915

Filed 5/20, 1915 [Signature] REGISTRAR

UNDERTAKER [Signature] ADDRESS Fulton 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, 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 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 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.)

N. B.—Every item of information should be carefully supplied. AGE announced EXACTLY. 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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CERTIFICATE OF DEATH

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

PLACE OF DEATH  
County Callaway  
Township MS Endicott  
or  
Village  
or  
City (NO. St. Ward)

Registration District No. 102 File No.  
Primary Registration District No. 5151 Registered No. 77

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

FULL NAME May Crawford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M

6 DATE OF BIRTH  
(Month) (Day) (Year)

7 AGE  
If LESS than 1 day..... hrs. or..... min.?

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

9 BIRTHPLACE  
(City or town, State or foreign country)

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied 1915  
that I last saw h..... alive on..... 1915  
and that death occurred, on the date stated above, at 12:21 a.m.

The CAUSE OF DEATH\* was as follows:  
Subacute Tuberculosis of tubercular tissue of lung

(Duration) 2 1/2 yrs..... mos..... ds.

CONTRIBUTORY (Secondary) She also has a paiter  
(Duration) several yrs..... mos..... ds.

(Signed) [Signature] M.D.  
May 21, 1915 (Address) Fulton Ma

\*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..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Satisfactory Information Supplied DATE OF BURIAL..... 191.....

20 UNDERTAKER ADDRESS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant).....  
(Address).....

15 Filed 5/25 1915  
Registrar

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