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

1 PLACE OF DEATH

County Cole

Township .....

Village .....

City Jefferson

Registration District No. 213-

File No. 33845

Primary Registration District No. 3014-

Registered No. 171-

(NO. 304 Union Ave St. Ward)

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

FULL NAME Evelah Frances Clinkerbeard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE MARRIED Single WIDOWED OF, DIVORCED (Write the word)

6 DATE OF BIRTH March 26 1916  
(Month) (Day) (Year)

7 AGE 6 yrs. 20 mos. ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry business, or establishment in which employed (or employer) nothing

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

10 NAME OF FATHER Alex Clinkerbeard

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Cole Co. Mo.

12 MAIDEN NAME OF MOTHER Jessie Hodge

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Morgan Co. Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Alex Clinkerbeard

(Address) Jefferson City Mo.

15 Filed Oct. 16- 1916 Audrey Jones Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 14 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 14 1916, to Oct 14 1916,

that I last saw h. is alive on Oct 14 1916 and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH\* was as follows: Acute Intestinal fever,

1190 (Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchitis (Duration) yrs. mos. 14 ds.

(Signed) Edu. Mansur M. D. (Address) Jefferson City Mo.

\*State the Disease Causing Death, in detail, in 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.

19 PLACE OF BURIAL OR REMOVAL Riverside Cemetery, Jeff. City DATE OF BURIAL 10/15 1916

20 UNDERTAKER Oliver & Herricks, Jeff. City Mo. 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*, *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.)

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 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 WASHINGTON, D. C.

## 1 PLACE OF DEATH

County *Coll*

Township

Village

City

2 FULL NAME

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

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Registration District No. *213*

File No.

Primary Registration District No. *3014*Registered No. *171*(NO. *304 Union Ave*) St.

Ward

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

## PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE yrs. mos. ds. 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, (or employer)

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

PARENTS 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)

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

15 Filed *Oct 16 1916* *Audrey Jones* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 14* 191 (Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *Satisfactory Information Supplied.* that I last saw h..... alive on ..... 191 (Year) and that death occurred, on the date stated above, at..... m.The CAUSE OF DEATH\* was as follows: *Acute Intestinal fever*CONTRIBUTORY (Secondary) *Acute Bronchitis* (Signed) *Chas. W. Mays* M. D. *Oct 14* 191 (Address) *Jeff. City Mo.*

\*State the Disease Causing Death or, in death 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.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191

20 UNDERTAKER ADDRESS

Original file, date, *Oct 16 1916*, 19.....

All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

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

33845

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*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), *29ds.*; *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.)