

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

9592

1 PLACE OF DEATH

County Laurance
Township Stolls City
or
Village Stolls City
or
City

Registration District No. 472 File No.
Primary Registration District No. 4285 Registered No. 3
St. Ward)

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

2 FULL NAME Matthew Ray Bredlow

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male
4 COLOR OR RACE White
5 SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
6 DATE OF BIRTH May 31 1906
(Month) (Day) (Year)
7 AGE 12 yrs 9 mos 15 ds
If LESS than 1 day...hrs. or...min.?

18 DATE OF DEATH Feb 15 1918
(Month) (Day) (Year)
17 I HEREBY CERTIFY that I attended deceased from Feb 10 1918 to 3-15 1918
that I last saw him alive on 3-15 1918
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Stomach Poisoning
177
(Duration) 8 yrs. 6 mos. 6 ds.

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

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. H. Haines M. D.
3/16 1918 (Address) Stolls City Mo

9 BIRTHPLACE (City or town, State or foreign country) Stolls City Mo
10 NAME OF FATHER W. M. Bredlow
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Newton Co Mo
12 MAIDEN NAME OF MOTHER Mary Stoll
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Stolls City 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?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Bredlow
(Address) Stolls City Mo

Former or usual residence.....
19 PLACE OF BURIAL OR REMOVAL St. Pauls Church Newton
DATE OF BURIAL 3/17 1918

15 Filed 3/16 1918 J. H. Clayton Registrar

20 UNDERTAKER W. Spencer ADDRESS Laurance Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Cause of death should be stated EXACTLY. PHYSICIANS should state whether or not deceased was ever in hospital or institution.

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, peritoneum*, 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.)

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

PLACE OF DEATH

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

County Lamar
Township _____
or
Village _____
or
City Stalls City (NO. _____ St.; _____ Ward)

Registration District No. 477 File No. _____
Primary Registration District No. 285 Registered No. 3

FULL NAME

Nathan Ray Bndlor

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED A
(Write the word)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

AGE _____ 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 (to employer) _____

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

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

(ADDRESS) _____

Filed May 16 1918 Joy B. Clayton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 15, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____ to _____, 191____, that I last saw him alive on _____, 191____

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

The CAUSE OF DEATH* was as follows:
Stomach Poisoning
Eating Salmon
(Duration) 16 yrs. 5 mos. 5 ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. C. Clayton M.D.
May 17 1918 (Address) Stalls City

*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 _____ 191____

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied
Satisfactory Information Supplied
Satisfactory Information Supplied
Satisfactory Information Supplied
Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

26516

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