

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

1 PLACE OF DEATH
County Greene
Township Stratford Registration District No. 5447 B File No. 33004
or Stratford Priority Registration District No. 944 Registered No. 20
City Stratford (No. 944) St. Stratford Ward 20
2 FULL NAME Margaret Ward

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)
6 DATE OF BIRTH Oct 9 1843
(Month) (Day) (Year)
7 AGE 75 yrs. 18 mos. 18 ds. If LESS than 1 day...hrs. or...min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) no
9 BIRTHPLACE (City or town, State or foreign country) Stratford Mo
PARENTS
10 NAME OF FATHER Caroline's father
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Mary Williams
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 27 1918
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from Oct 17th 1918 to Oct 21 1918, that I last saw her alive on Oct 21 1918, and that death occurred, on the date stated above, at 11:30 m.
The CAUSE OF DEATH* was as follows:
Myocarditis cirro
(Duration) 7 yrs. 0 mos. 0 ds.
CONTRIBUTORY (Secondary) 0
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) Dr. H. Frost M.D. M. D.
1073rd Stratford Mo
*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Grantham
(Address) Stratford Mo

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted if not at place of death?
Former or usual residence 0

15 Filed Nov 1 1918 by J. M. Foster Registrar

19 PLACE OF BURIAL OR REMOVAL Danforth DATE OF BURIAL Oct 28 1918
20 UNDERTAKER J. M. Kline ADDRESS Stratford Mo

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

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County

Township

or
Village

or
City

Registration District No. File No.

Primary Registration District No. Registered No.

City

St. Ward)

(NO)

2 FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS	
3 SEX	4 COLOR OR RACE 5 SINGLE 6 MARRIED 7 WIDOWED 8 OR DIVORCED (Write the word)
6 DATE OF BIRTH	..... yrs. mos. ds. (Month) (Day) (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)	.....
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, 191..... Registrar

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH	..... (Month) (Day) (Year)
17	I HEREBY CERTIFY, that I attended deceased from to 191.....
	that I last saw h..... alive on 191.....
	and that death occurred, on the date stated above, at..... m.
	The CAUSE OF DEATH* was as follows—

	..... (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)	.....
(Signed)	..... (Duration) yrs. mos. ds.
	..... 191..... (Address) M. D.
*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

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**

1. PLACE OF DEATH

County St. Louis Registration District No. 944 File No. _____
 Township Graysville Primary Registration District No. 5447 Registered No. 20
 City _____ (No. _____ St. _____ Ward)

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ mos.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work Home Keeper
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT Im Grunthig (Address) 2020 E. 12th St

15. FILED 11-14-1918 Jos. J. Forts REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 27 1918

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I had seen him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis
 (duration) 2 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) none
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. H. Foster, M. D.
 , 19____ (Address) Shabbonno

*State the DISEASE CAUSING DEATH, or in Deaths from VIOLENCE CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Dunbouth Cem 11-29-18

20. UNDERTAKER J. W. Klugin ADDRESS Springuey

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

33004

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*, *Composer*, *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) *Colton 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*; *Broncho-pneumonia* ("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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.