

PLACE OF DEATH

County Ray
Township Fishing River
or
Village
or
City

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

Registration District No. 743 File No. 9844
Primary Registration District No. 6237 Registered No. 15

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

FULL NAME Daniel Clevergord

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
<u>Male</u>	<u>White</u>	<u>Widowed</u>

DATE OF BIRTH

Dec. 24, 1842
(Month) (Day) (Year)

AGE	IF LESS than 1 day, ____ hrs. or ____ min.?
<u>72 yrs. 2 mos. 29 ds.</u>	

OCCUPATION
(a) Trade, profession, or
particular kind of work

Farmer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE
(City or town,
State or foreign country)

No.

PARENTS

NAME OF
FATHER

Pitman Clevergord

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

Tenn.

MAIDEN NAME
OF MOTHER

Mrs. Mc. Ray

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

Dixie, Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Clevergord

(Address)

Bowgill, Mo.

Filed Mar. 24, 1915.

L. G. Bellis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar. 23, 1915.
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 18, 1915, to March 23, 1915, that I last saw him alive on Mar. 22, 1915, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

107A
162 (Duration) yrs. mos. 16 ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

8 (Signed) W. S. Harry M. D. F.
3-7-15 (Address) McElroy Springs, 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 43 yrs. mos. ds. In the 72 yrs. 2 mos. 29 ds.

Where was disease contracted
If not at place of death?

Former or
usual residence New Exhale Springs, Mo.

PLACE OF BURIAL OR REMOVAL

New Garden Church yard Mar. 25, 1915.

UNDERTAKER

ADDRESS

E. C. Entwistle Exhale Springs, Mo.

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 septicæmia*," "*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.)

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 743File No. 62137Primary Registration District No. 62137Registered No. 15

St.: _____ Ward: _____

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

FULL NAME

Daniel Oliveray

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
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DATE OF BIRTH

Satisfactory Information Supplied
 (Month) 1 (Day) 1 (Year) 1915

AGE

IF LESS than
1 day, 0 hrs.
or 0 mins.
mos. 0 ds. 0

OCCUPATION

(a) Trade, profession, or
particular kind of work None
 (b) General nature of industry,
business, or establishment in
which employed (or employer) None

BIRTHPLACE

(City or town,
State or foreign country) None

NAME OF FATHER

Information Supplied
 BIRTHPLACE OF FATHER
(City or town, State or foreign country) None

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) None

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) None

(Address) Excelsior Springs Mo.

Ellied 3/24 1915

May 24 1915

Information Supplied
 REGISTRAR

MAR

1015

Original date, date

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Information Supplied
 Mar 23, 1915
 (Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from
1915, to 1915, that I last saw him alive on 1915,

and that death occurred, on the date stated above, at 9 a.m.
 The CAUSE OF DEATH* was as follows:

Pneumonia

This was a case of Broncho-
Pneumonia

Contributory (SECONDARY) senility
 (Duration) yrs. mos. ds.

(Signed) S. H. Henry M.D.
 3-24, 1915 (Address) Excelsior Springs

*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 C. DATE OF BURIAL 1915

UNDERTAKER

ADDRESS

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]

9844

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