

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH
County Stoddard
Township Duck Creek
or
Village _____
or
City _____ (NO. _____ St. _____ Ward)

Registration District No. 1840 File No. 29471 Ent'd
Primary Registration District No. 0102 Registered No. _____

FULL NAME Guy T. Wilson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH 6 10 1846
(Month) (Day) (Year)

AGE 64 yrs. 3 mos. 13 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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) State of Ky

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
MAIDEN NAME OF MOTHER Allie Key
BIRTHPLACE OF MOTHER (City or town, State or foreign country) State of Ky

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

(ADDRESS) Asherville Mo

Filed Sept 23 1910 L. Burr REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 17, 1910 to Sept 23, 1910
that I last saw him alive on Sept 22, 1910,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Pneumonia
5.3E

(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) _____ M. D.
1910 (Address) _____

*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 Hobbs Chapel DATE OF BURIAL Sept 24 1910

UNDERTAKER J. A. Beckman ADDRESS Purvis 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*, *Sar-*

coma, 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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PLACE OF DEATH
County Stoddard
Township Duck Creek
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
Registration District No. 840 File No. 29471
Primary Registration District No. 6102 Registered No. X

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

FULL NAME Guy T. Wilson

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> <small>(Write the word)</small>	DATE OF DEATH <u>X Sept 22</u> , 191 <u>0</u> <small>(Month) (Day) (Year)</small>	
DATE OF BIRTH <u>June 10th</u> , 19 <u>46</u> <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from <u>Sept 17</u> , 191 <u>0</u> , to <u>Sept 23</u> , 191 <u>0</u> , that I last saw him alive on <u>Sept 22</u> , 191 <u>0</u> , and that death occurred, on the date stated above, at _____ m.	
AGE <u>64 yrs. 3 mos. 13 ds.</u>		If LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as-follows: <u>Cancer</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____				
BIRTHPLACE (City or town, State or foreign country) <u>State of Ky.</u>			(Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>X</u>	Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>	(Signed) <u>X L Burns</u> M. D. <u>Sept 22</u> , 191 <u>0</u> (Address) <u>X Puxico Mo</u>		
	MAIDEN NAME OF MOTHER <u>Alma Key</u>	*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) <u>State of Ky.</u>	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) <u>Luther Wilson</u> (ADDRESS) <u>Cashville, Mo.</u>			Where was disease contracted If not at place of death? _____ Former or usual residence _____	
Filed <u>X Sept 19</u> , 191 <u>0</u> <u>X L Burns</u> REGISTRAR		PLACE OF BURIAL OR REMOVAL <u>Stobbs Chapel</u>		DATE OF BURIAL <u>Sept 24</u> , 191 <u>0</u>
		UNDERTAKER <u>J. C. Hickman</u>		ADDRESS <u>Puxico, Mo.</u>

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]

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