

CAUSE OF DEATH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important.

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

PLACE OF DEATH  
County Dallas  
Township Jackson  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

~~744~~

Registration District No. 243 File No. 9912  
Primary Registration District No. 6336 Registered No. 1

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

FULL NAME Albert Wings

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

DATE OF BIRTH Feb - 9, 1857  
(Month) (Day) (Year)

AGE 60 yrs. 18 mos. 18 ds. If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

DATE OF DEATH Feb - 1, 1917  
(Month) (Day) (Year)

OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) 1-000

I HEREBY CERTIFY, that I attended deceased from Nov 7 -, 1910, to Feb 28, 1911, that I last saw him alive on Feb - 28, 1911, and that death occurred, on the date stated above, at 530A, m. The CAUSE OF DEATH\* was as follows:

BIRTHPLACE  
(City or town, State or foreign country) Dallas Co Mo.

My Cause of Death 55D  
My (Duration) yrs. 4 mos. \_\_\_\_ ds.

PARENTS

NAME OF FATHER John C Wings

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

MAIDEN NAME OF MOTHER Elizabeth J. Williams

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

Contributory (SECONDARY) Paralysis  
(Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) H. A. Giffney M. D.  
3-7-1917 (Address) Elkland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Albert Wings  
(ADDRESS) Elkland

\*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 RESIDENCE)  
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 \_\_\_\_\_

Filed 2 1917  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Elkland  
DATE OF BURIAL Jan 2, 1917

UNDERTAKER W. Baird  
ADDRESS Elkland 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*, *peritoneum*, 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 septichaemia," "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 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

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
 County Dallas  
 Township Jackson  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 243  
 Primary Registration District No. 5336

File No. 9912 #  
 Registered No. 1

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

FULL NAME Albert Wingo

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Married  
 DATE OF BIRTH Feb. 9, 1857  
 (Month) (Day) (Year)  
 AGE 60 yrs. 18 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) Dallas Co. Mo.  
 NAME OF FATHER Mr. C. Wingo  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind.  
 MAIDEN NAME OF MOTHER Elizabeth Wingo  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Mrs Albert Wingo  
 (ADDRESS) Elkhart

Filed Mar 10 1911 W. M. White  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 7, 1911  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from Nov. 7, 1911, to Jan 28, 1911, that I last saw him alive on Jan. 28, 1911, and that death occurred, on the date stated above, at 2:20 m.  
 The CAUSE OF DEATH\* was as follows:  
Tumor of Brain

(Duration) yrs. 4 mos. \_\_\_ ds.  
 Contributory Paralysis  
 (SECONDARY) (Duration) yrs. 3 mos. \_\_\_ ds.  
 (Signed) G. A. Meyer M. D.  
3-7 1911 (Address) Buffalo

\*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 Union Mount DATE OF BURIAL Mar 2, 1911  
 UNDERTAKER W Baird ADDRESS Elkhart Mo.

All information called for must be written on this Supplementary Certificate

Original file date \_\_\_\_\_, 1911

# Revised United States Standard Certificate of Death

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

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