

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

PLACE OF DEATH

County Ballaway
Township Balwood
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 108 File No. 40711
Primary Registration District No. 5757 Registered No. _____

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

FULL NAME Thos. Muzzie

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 June 14th, 1850
(Month) (Day) (Year)

DATE OF DEATH October 14, 1911
(Month) (Day) (Year)

AGE 61 yrs. 4 mos. 4 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

I HEREBY CERTIFY, that I attended deceased from July 1st, 1910, to Oct. 14th, 1911, that I last saw him alive on Oct. 12th, 1911, and that death occurred, on the date stated above, at 8 A. m.

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

The CAUSE OF DEATH* was as follows:
Bright's Disease
131
(Duration) 2 yrs. ____ mos. ____ ds.

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

Contributory (Secondary) _____ (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) _____ M. D.
_____, 1911 (Address) _____

PARENTS
NAME OF FATHER Edward Muzzie
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Elizabeth Swank
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Blara Smith
(ADDRESS) Balwood Mo.

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 _____

Filed Dec 10, 1911 M. S. Simcoe
REGISTRAR

PLACE OF BURIAL OR REMOVAL Anglaise Church DATE OF BURIAL Oct 15th, 1911
UNDERTAKER Ed. Herndon Fulton 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.

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 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.)



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

PLACE OF DEATH
 County Callaway
 Township Calwood
 or
 Village _____
 or
 City _____ (NO _____)

Registration District No. 108 File No. _____
 Primary Registration District No. 5157 Registered No. _____
 St.: _____ Ward: _____

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

FULL NAME Thos. Muzzie

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
 DATE OF BIRTH June 14th, 1850
 (Month) (Day) (Year)
 AGE 61 yrs. 4 mos. ds.
 If LESS than 1 day, ____ hrs. or ____ min.?

DATE OF DEATH Oct. 14, 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from July 1, 1911, to Oct. 14, 1911,
 that I last saw him alive on 12, 1911,
 and that death occurred, on the date stated above, at 8 a. m.

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

The CAUSE OF DEATH* was as follows:
Bright's Disease

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

PARENTS
 NAME OF FATHER Edward Muzzie
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
 MAIDEN NAME OF MOTHER Elizabeth Swank
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

(Duration) 2 yrs. ____ mos. ____ ds.
 Contributory (SECONDARY) _____
 (Duration) ____ yrs. ____ mos. ____ ds.
 (Signed) _____ M. D.
 _____, 1911 (Address) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Lelara Smith
 (ADDRESS) Calwood 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 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 Oct. 15, 1911 Reuben S. Simons
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Arxvasse Church DATE OF BURIAL Oct. 15, 1911
 UNDERTAKER Ed. Herndon ADDRESS Fulton

Revised United States Standard Certificate of Death

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

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