

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
 County Way
 Township Gallatin
 or Village Midway
 or City Midway Clay Co Mo

 Registration District No. 193 File No. 25752
 Primary Registration District No. 5276 Registered No. 16
(NO. Midway Clay Co Mo St. Ward)

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

FULL NAME W M Shetterworth

PERSONAL AND STATISTICAL PARTICULARS

 SEX male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)

 DATE OF BIRTH Aug 22 1846
(Month) (Day) (Year)

 AGE 66 yrs. 6 mos. 6 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

 OCCUPATION Laborer
(Trade, profession, or particular kind of work)
 General nature of industry, business, or establishment in which employed (or employer) 3-07

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

 NAME OF FATHER Philip Shetterworth

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

 MAIDEN NAME OF MOTHER Fanny Edwards

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 Informant) W M Shetterworth
 (ADDRESS) No. 100

 Died Aug 22 1912

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 DATE OF DEATH Aug 22 1912
(Month) (Day) (Year)

 I HEREBY CERTIFY, that I attended deceased from Feb 10, 1912, to Aug 22, 1912, that I last saw him alive on Aug 22, 1912, and that death occurred, on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

25A
162
Ordinary Tuberculosis
 (Duration) 16 yrs. 2 mos. 2 ds.

 Contributory Old Age
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

 (Signed) W M Dagg M. D.
Aug 23, 1912 (Address) Worlesville 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. 6 mos. ___ ds. In the State 50 yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

 PLACE OF BURIAL OR REMOVAL No German Cemetery, Lane Oak DATE OF BURIAL Aug 24 1912

 UNDERTAKER E. Stuehl & Son, Midway ADDRESS 408 E 9

W. F. Stuehl

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

County.....
Township.....
or
Village.....
or
City..... (NO.....)

Registration District No. File No.
Primary Registration District No. Registered No.
St. Ward

If death occurred
hospital or institution
give its NAME
of street and place

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)	(Day)
AGE yrs. mos. ds.	IF LESS than 1 day, hrs. or min.?
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country)		
PARENTS		
NAME OF FATHER		
BIRTHPLACE OF FATHER (City or town, State or foreign country)		
MAIDEN NAME OF MOTHER		
BIRTHPLACE OF MOTHER (City or town, State or foreign country)		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
..... (Month)

..... (Day)

..... 191.....

I HEREBY CERTIFY, that I attended deceased from
....., 191..... to....., 191.....
that I last saw h..... alive on....., 191.....
and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

Contributory
(SECONDARY)

(Signed).....

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

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

..... 191..... (Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSFER RECENT RESIDENTS)

At place of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted
..... if not at place of death?

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

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 Clay
Township Gallitan
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 197 File No. 25752
Primary Registration District No. 5276 Registered No. 16

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

FULL NAME W. M. Shettleworth

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED widowed WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Aug. 22, 1846
(Month) (Day) (Year)
AGE 66 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

DATE OF DEATH Aug. 22, 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Feb. 10, 1912, to Aug. 22, 1912, that I last saw him alive on Aug. 22, 1912, and that death occurred, on the date stated above, at 8 p. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

BIRTHPLACE (City or town, State or foreign country) Kentucky
PARENTS NAME OF FATHER Phillip Shettleworth BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER Fanny Edwards BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

(Duration) yrs. 6 mos. 22 ds.
Contributory Old age (SECONDARY)
(Duration) yrs. _____ mos. _____ ds.
(Signed) H. M. Dagg M. D.
Aug. 23, 1912 (Address) Harlem Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Shettleworth
(ADDRESS) Harlem 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 10/6/12 at St. J. Ward REGISTRAR

PLACE OF BURIAL OR REMOVAL Linn Creek, Mo. DATE OF BURIAL Aug. 24, 1912
UNDERTAKER W. F. Stine ADDRESS 408 E. 9

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, 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 *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.)