

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty MissTownship OhioRegistration District No. 569File No. 36672

Village _____

Primary Registration District No. 5765

Registered No. _____

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Bill Scagg

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>Out know</u> (Month) (Day) (Year)		
AGE <u>37</u> yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work 9-0
(b) General nature of Industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Out knowNAME OF FATHER Frank LynchBIRTHPLACE OF FATHER (City or town, State or foreign country) Out knowMAIDEN NAME OF MOTHER Out knowBIRTHPLACE OF MOTHER (City or town, State or foreign country) Out know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Scagg

(ADDRESS) _____

Filed 11/10 1912 E. J. Rowley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 28, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 20, 1912, to Oct 28, 1912, that I last saw her alive on Oct 6, 1912, and that death occurred, on the date stated above, at about 2:00 p.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
23A

25 about 7 (Duration) 2 yrs. _____ mos. _____ ds.

Contributory Tuberculosis
(SECONDARY) about (Duration) 2 yrs. _____ mos. _____ ds.

(Signed) John T. Boone M. D.
Oct 28, 1912 (Address) Cherleston 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 _____

PLACE OF BURIAL OR REMOVAL Cherleston Mo DATE OF BURIAL 10/29, 1912UNDERTAKER Pair LHM Co ADDRESS Cherleston Mo

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*, *Composer*, *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 "Asihenia," "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 Mississippi
 Township Ohio
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 5769 File No. _____
 Primary Registration District No. 5765 Registered No. 17

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

FULL NAME Belle Scaggs

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED m
(Write the word)

DATE OF DEATH Oct 28, 1912
(Month) (Day) (Year)

DATE OF BIRTH _____, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 20, 1912, to Oct 28, 1912, that I last saw her alive on Oct 6, 1912, and that death occurred, on the date stated above, at 6:30 a.

AGE 37 yrs. _____ mos. _____ ds.
If LESS than 1 day, _____ hrs. _____ or _____ min.

The CAUSE OF DEATH* was as follows:

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

Pulmonary Tuberculosis

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

NAME OF FATHER Frank French

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

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

Contributory Tubercular arthritis
 (SECONDARY) (Duration) adv yrs. 2 mos. 2 ds.

MAIDEN NAME OF MOTHER _____

(Signed) John C. Bone M. D.
 1912 (Address) Charleston Mo

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

*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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) John Scaggs

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) X Birds Point Mo X

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

Filed 11/17 1912 E. F. Rawls REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Rusher Ridge DATE OF BURIAL 10/29 1912

UNDERTAKER Lair F. Ume Co. ADDRESS Charleston Mo

Original file, date OCT 1922

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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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*; *Reverber wound of head—homicide*; *Poisoned by carbonic 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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