

WRITE PLAINLY, WITH UNFRA

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 Morgan
Township Muleau
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 594 File No. 3 16768
Primary Registration District No. 5792. a Registered No. _____

FULL NAME James Manuel Ferguson (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 widower
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH July 7, 1836
(Month) (Day) (Year)

AGE 77 yrs. 10 mos. 12 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) Farm work.

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

PARENTS
NAME OF FATHER Edman Ferguson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Lucinda Buckner
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Taylor
(ADDRESS) Versailles

Filed 5/31 1914 W. L. Hadler REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 19, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 3, 1914, to May 19, 1914, that I last saw him alive on May 16, 1914, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Bronchitis
95 B
106 D 3 weeks
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory Hypertrophy Heart
(SECONDARY) 8 unknown (duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. J. Wheat M. D.
May 21, 1914 (Address) Barnett

*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 Hopewell DATE OF BURIAL May 21, 1914
UNDERTAHER Albert Kidwell ADDRESS Versailles

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.)



DING INK—THIS IS A PERMANENT RECORD.

Information sh a fully set. If omitted, F. not of some 1 of OCCUPATION is very important.

PLACE OF DEATH

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

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

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

Registration District No. 597 File No. _____
Primary Registration District No. 57929 Registered No. 3

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

FULL NAME

James Manuel Ferguson

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH 7/4 - 1836
(Month) (Day) (Year)
Satisfactory Information

AGE 77 yrs. 10 mos. 2 ds. IF LESS than 1 day, ___ hrs. or ___ min.

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

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

PARENTS
NAME OF FATHER Edman Ferguson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Luinda Buchanan
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Taylor
(ADDRESS) Verailles Mo.

Filed 5/21 1914 W. L. Hatler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 5 / 19 / 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 191____,
that I last saw him alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Boonchitis

Contributory (SECONDARY) Hypertrophy Heart
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. J. Heat M. D.
5/21 1914 (Address) Barnett 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 usual residence

PLACE OF BURIAL OR REMOVAL Hopewell DATE OF BURIAL 5/21 1914

UNDERTAKER Albert Kidwell ADDRESS Verailles Mo.

Original file, date May 1914 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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/6768

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.)