

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

PLACE OF DEATH

County Cass
Township Jolua
or
Village Freeman
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 153
Primary Registration District No. 4087

File No. 31716
Registered No. 10

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

FULL NAME Henry Begley

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
DATE OF BIRTH <u>Mar 9, 1830</u> (Month) (Day) (Year)		
AGE <u>84 yrs. 7 mos. 19 ds.</u> If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Formerly Farmer 92A</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>125</u>		

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

PARENTS	NAME OF FATHER <u>Pleasanton Begley</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Illinois</u>
	MAIDEN NAME OF MOTHER <u>Marrilla Rogers</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Illinois</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE:
(Informant) Mrs M. A. Arnold
(ADDRESS) Freeman Mo

Filed Oct 29, 1914 R. G. Keller
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 28, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June, 1913, to Oct 27, 1914, that I last saw him alive on Oct 27, 1914, and that death occurred, on the date stated above, at 6³⁰ a.m.

The CAUSE OF DEATH* was as follows:
Old age, + Disease of heart + Kidneys

(Duration) 1 yrs. 4 mos. ds.
Contributory (SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. G. Keller M. D.
Oct 29, 1914 (Address) Freeman 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 Freeman Mo DATE OF BURIAL Oct 29, 1914
UNDERTAKER H. Austin ADDRESS Freeman 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 "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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Chas
Township _____
or
Village Freeman
or
City _____

Registration District No. 153 File No. _____
Primary Registration District No. 4087 Registered No. 10
St. _____ Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Oct 28 1914
(Month) (Day) (Year)

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

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

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

the CAUSE OF DEATH* was as follows:
Old age & Disease of heart
& Kidneys
Trinital Regeneration
(Duration) 1 yrs. 4 mos. 4 ds.

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

Contributory _____
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
R. G. Kelley
Oct. 29 1914 (Address) Freeman Mo.

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) _____

*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) _____

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 _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

Filed Oct 29 1914 R. G. Kelley REGISTRAR

UNDERTAKER _____ ADDRESS _____

should be carefully supplied. AGE should be stated. Exact statement of cause of death should be given. If death occurred in a hospital or institution, give its name instead of street and number.

SUPPLEMENTARY
Satisfactory Information Supplied

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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31716
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