

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

PLACE OF DEATH
County McDonald
Township Osage
or
Village
or
City (NO. _____ St.; _____ Ward)

Registration District No. 57 File No. _____
Primary Registration District No. 5687 Registered No. 5339

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

FULL NAME William M. Legate

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (write the word) Married
DATE OF BIRTH June 15 1858
(Month) (Day) (Year)

AGE 72 yrs. 7 mos. 5 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER James Legate
BIRTHPLACE OF FATHER (City or town, State or foreign country) West Virginia
MAIDEN NAME OF MOTHER Greenma Neal
BIRTHPLACE OF MOTHER (City or town, State or foreign country) West Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. H. Legate
(ADDRESS) Southwest City, Mo

Filed Feb. 1 1915 J. P. Beeson
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 10 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 2, 1915, to Jan 10, 1915, that I last saw him alive on Jan 10, 1915, and that death occurred, on the date stated above, at 8:25 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of liver

(Duration) 3 yrs. ____ mos. ____ ds.

Contributory Branches Pneumonia
(SECONDARY)

(Duration) ____ yrs. ____ mos. 14 ds.
(Signed) S. V. Pozner M. D.
Jan. 14 1915 (Address) St. City, 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 City Cemetery DATE OF BURIAL 10/2 1915

UNDERTAKER J 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 (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.)

PLACE OF DEATH

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

County

McDonald
Praine

Registration District No.

517

File No.

Township or Village or City

Primary Registration District No.

5687

Registered No.

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

FULL NAME

William M Fugate

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

M

W

M

DATE OF DEATH

Jan 10, 191*5*
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

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

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

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)

BIRTHPLACE

(City or town, State or foreign country)

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

71 191*5*

REGISTRAR

W. M. Fugate

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

191____ (Address) M. D.

*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

DATE OF BURIAL

City Cemetery

1-12, 191*5*

UNDERTAKER

ADDRESS

Wink Bros.

St. Louis

Original file, date.

Feb - 15

All information called for must be written on this Supplementary Certificate.

ALL INFORMATION SHOULD BE PLAINLY WRITTEN IN PLAIN TERMS. EXACT STATEMENT OF DEATH IN PLAIN TERMS. AGE SHOULD BE STATED EXACTLY. SEX SHOULD BE PROPERLY CLASSIFIED. EXACT STATEMENT OF DEATH IN PLAIN TERMS.

SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

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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.)

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