

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

PLACE OF DEATH

County Franklin
Township Central
or
Village Marionville
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 291 File No. 27594
Primary Registration District No. 54096a Registered No. 7

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

FULL NAME

Guss August Inge

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>Negro</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Sept 11 1891</u> (Month) (Day) (Year)		
AGE <u>24</u> yrs. mos. ds.		If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Franklin Co</u>		
PARENTS	NAME OF FATHER <u>Andrew Inge</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Franklin Co</u>	
	MAIDEN NAME OF MOTHER <u>Eliza Ford</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Jefferson Co Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sylvester Inge</u> (ADDRESS) <u>Alton Ill</u>		
Filed <u>Aug 20</u> 191 <u>6</u>	W. A. Fisher REGISTRAR	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 20 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1916 to _____, 1916,
that I last saw him live on Aug 20 1916,
and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:
Gunshot wound, hands of
Thomas Kingston
Verdict of jury
170 (Duration) yrs. mos. ds.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.
(Signed) M. Quiller (Coroner) M. D.
Angro 1916 (Address) Labadie 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 West Cary Cemetery DATE OF BURIAL Aug 21 1916
UNDERTAKER Web Duokworth ADDRESS St. Clair Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Township

or

Village

or

City

Franklin
Central

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

Registration District No.

291

File No.

Primary Registration District No.

5409^a

Registered No.

7

(NO.

St.

Ward)

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

2 FULL NAME

August Inge

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

B.

5 SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

S

6 DATE OF BIRTH

Satisfactory

(Month)

(Day)

1

(Year)

7 AGE

yrs. mos. ds.

If LESS than
1 day.....hrs.
or.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

SUPPLEMENTARY
Satisfactory Information supplied.

9 BIRTHPLACE

(City or town,
State or foreign country)

PARENTS

10 NAME OF
FATHER

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

12 MAIDEN NAME
OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Aug 20 1916

1916

W. B. Fisher
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

Aug. 20 1916

17

Satisfactory

Information supplied.

Gunshot wound hands of
Thomas Houston Homeidell

(Duration) 18 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. C. Miller, Coroner
Aug. 20 1916 (Address) Laddie Ave

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(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
or Recent Residents)

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

Where was disease contracted
if not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20 UNDERTAKER

ADDRESS

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

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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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *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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