

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

38142

1 PLACE OF DEATH  
*Macon*  
County  
Township  
or  
Village *Ethel*  
or  
City

Registration District No. *531* File No. ~~4317~~  
Primary Registration District No. *4317* Registered No. *27*  
St. Ward

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

2 FULL NAME *Brigance Huntsman*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *W*  
(Write the word)

16 DATE OF DEATH *Nov 24*, 191*6*  
(Month) (Day) (Year)

6 DATE OF BIRTH *Oct 15*, 191*6*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Nov 14*, 191*6*, to *Nov 24*, 191*6*, that I last saw him alive on *Nov 23*, 191*6*, and that death occurred, on the date stated above, at *6 a.m.*

7 AGE *86* yrs. *1* mos. *9* ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH\* was as follows: *Nov 24-16*

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

*Cerebral Hemorrhage*  
*& Broken High-bone*

9 BIRTHPLACE (City or town, State or foreign country) *Ky*

(Duration) yrs. mos. ds. *10*

10 NAME OF FATHER *Unknown*

CONTRIBUTORY *Arteriosclerosis*  
(Secondary)

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

(Duration) yrs. mos. ds. *10*

12 MAIDEN NAME OF MOTHER *Sarah E Brock*

(Signed) *W E Bradley* M. D.

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

*Nov 24*, 191*6* (Address) *Ethel Mo*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *J H Sewell*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

(Address) *Ethel Mo*

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

15 Filed *Nov 24*, 191*6* *A H Bradley*

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 *Cario Mo*

19 PLACE OF BURIAL OR REMOVAL *Cario Cemetery* DATE OF BURIAL *Nov 25*, 191*6*

20 UNDERTAKER *H C Young* ADDRESS *Ethel Mo*

Registrar

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*, *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

1 PLACE OF DEATH  
 County Macon  
 Township or Village or City Ethel

Registration District No. 531 File No. \_\_\_\_\_  
 Primary Registration District No. 4317 Registered No. 27  
 (NO. St. Ward)

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

2 FULL NAME Benjamin Huntsman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED Wid  
 (Write the word)

16 DATE OF DEATH 11-24-1916  
 (Month) (Day) (Year)

6 DATE OF BIRTH \_\_\_\_\_ (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him/her alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

The CAUSE OF DEATH was as follows:

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

General Paralysis of Brain type - low  
Had a stroke paralysis  
due at Institution of Frost 10 ds.

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

CONTRIBUTORY (Cause) Chorea telurosis  
 (Signed) W. C. Bradley M. D.  
11/24, 1916 (Address) Ethel Mo

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)

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 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 \_\_\_\_\_

(Informant) \_\_\_\_\_  
 (Address) \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

15 Filed 11/24, 1916 J. A. Bradley Registrar

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
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*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 "Asthemia," "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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