

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

V. S. No. 2.

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.

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

MARGIN RESERVED FOR BINDING

PLACE OF DEATH
County Ray
Township Cambden
or
Village Cambden
or
City _____ (NO. _____)

Registration District No. 789 File No. 15957
Primary Registration District 4441 Registered No. _____
St. _____ Ward _____

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

FULL NAME Otto McGinnis

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE 23 yrs. 1 mos. 3 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

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

PLACE OF BIRTH _____
City or town, State or foreign country

NAME OF FATHER Strother McGinnis

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

MAIDEN NAME OF MOTHER Ann H. Hoins

BIRTHPLACE OF MOTHER Clay Co. Mo
(City or town, State or foreign country)

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Parent) Strother McGinnis

(ADDRESS) Richmond Mo

4-18 1917 W. W. Burgess
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 18 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 18, 1917, to April 18, 1917, that I last saw him alive on April 18, 1917, and that death occurred, on the date stated above, at 11 am. The CAUSE OF DEATH* was as follows:

1 Suicide by gunshot
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. L. Burk M. D. (Address) Cambden 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 RESIDENCE)
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 Trudels Chapel DATE OF BURIAL 4-20 1917
UNDER-TAKER W. W. Burgess ADDRESS Cambden Mo

PLACE OF DEATH

County Ray
 Township Bartholomew
 or
 Village
 or
 City

Registration District No. _____
 Primary Registration District No. _____
 File No. _____
 Registered No. _____

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

St. _____
 Ward _____
 Full Name Otto McQuinn

PERSONAL AND STATISTICAL PARTICULARS

SEX Male
 COLOR OR RACE White
 MARRIAGE STATUS Married
 (If married, give name of spouse)
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 AGE 23 yrs. 13 mos. 1 ds.
 If LESS than 1 day, _____ hrs. or _____ min.?

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) Clay Co. Mo.

NAME OF FATHER Arthur McQuinn
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Bartholomew
 MAIDEN NAME OF MOTHER Ann W. McQuinn
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Clay Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant's Name) Arthur McQuinn
 (ADDRESS) Richwood Mo.

Filed 4-15 1917 W. W. Burgess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 18 (Month) 18 (Day) _____ (Year)
 I HEREBY CERTIFY, that I attended deceased April 18, 1917, to April 18, 1917, that I last saw alive on April 18, 1917, and that death occurred, on the date stated above, at Mo.
 The CAUSE OF DEATH was as follows:
Suicide by gun shot.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos.
 (Signed) Kamuel Harris Brown (Duration) _____ yrs. _____ mos.
April 15, 1917 (Address) Bartholomew

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT PLACE RESIDENTS)
 At place of death _____ yrs. _____ mos. In the State _____ yrs. _____ mos.
 Where was disease contracted if not at place of death _____
 Former or actual residence _____

PLACE OF BURIAL OR REMOVAL Waltham Park
 DATE OF BURIAL 4-19
 UNDERTAKER W. W. Burgess
 ADDRESS Clay Co. Mo.

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state

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

MARGIN RESERVED FOR BINDING

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

1 PLACE OF DEATH

County *Ray*

Township

Village

City *Cassden*

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

Registration District No. *139*

File No.

Primary Registration District No. *4441*

Registered No.

(No. *Atto Mc Grinnis*)

St.

Ward

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*

4 COLOR OR RACE *W*

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *S*

6 DATE OF BIRTH

(Month)

(Day)

(Year) *1894*

7 AGE

about 23 yrs. *0* mos. *0* 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)

9 BIRTHPLACE

(City or town, State or foreign country)

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 *6/11* 1917

1917

Registrar *M. H. Ruggles*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year) *1917*

17 I HEREBY CERTIFY, that I attended deceased from

that I last saw him *live* on *April 15*, 1917, to *April 18*, 1917,

and that death occurred on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* *gun shot by husband* follows:

Murder

(Duration) *18* yrs. *0* mos. *0* ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

June 8, 1917. (Address) *Cassden Mo*

*State the Disease Causing Death, or, in deaths from violent Causes, state (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. mos. 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

1917

20 UNDERTAKER

ADDRESS

Original file, date *4/18*

1917

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

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.

DO NOT WRITE IN THESE SPACES. WITH UNFADING INK—THIS IS A

SUPPLEMENTARY INFORMATION SUPPLIED

Satisfactory Information Supplied

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);

1505
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), *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.)