

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

1 PLACE OF DEATH

County Bollinger
Township Lorraine
or
Village
or
City

Registration District No. 67 File No. 21280-A
Primary Registration District No. 5702C Registered No. 29
St. Ward

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

2 FULL NAME Daisy Irene Huzman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE single
MARRIED
WIDDED
OR DIVORCED
(Write the word)
6 DATE OF BIRTH June 1, 1915
(Month) (Day) (Year)
7 AGE 2 yrs. 19 ds.
If LESS than
1 day...hrs.
or...min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer)

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

PARENTS
10 NAME OF FATHER Charley Huzman
11 BIRTHPLACE OF FATHER: (City or town, State or foreign country) Loplin Mo
12 MAIDEN NAME OF MOTHER Idea Bell Boston
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Loplin Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley Huzman
(Address) Loplin Mo.

15 Filed 7/14 1917 of C. A. Sanders
Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 20, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 21, 1917 to June 20, 1917, that I last saw her alive on June 19, 1917, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia complicated with Cholera Infantum
12:0 A

108 (Duration) yrs. mos. 29 ds.

CONTRIBUTORY Cholera Infantum
(Secondary) (Duration) yrs. mos. 21 ds.

(Signed) J. M. Ginnery M. D.
June 20, 1917 (Address) Whitewater 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 Barker Chapel DATE OF BURIAL 6/20, 1917

20 UNDERTAKER A. R. Lattin ADDRESS Lutesville Mo.

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 "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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH

County Bellinger
 Township Loraine
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

Registration District No. 67 File No. _____
 Primary Registration District No. 5102-9 Registered No. 29

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

2 FULL NAME

Saisy Gene Hugman

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 June 7 1915
 (Month) (Day) (Year)

7 AGE 2 yrs. 19 mos. 19 ds.
 If LESS than 1 day _____ hrs. or _____ min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Lafayette Mo.

10 NAME OF FATHER Charles D. Hugman

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

12 MAIDEN NAME OF MOTHER Lola Bell Boston

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Charles Hugman
 (Address) Lafayette Mo.

15 Filed Aug 6 1918 Registrar Ed Stinson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 20 1918
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 1918, to June 20 1918, that I have had information supplied, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Pneumonia Complicated with Cholera Infantum
Lobar Pneumonia
 (Duration) _____ yrs. _____ mos. 21 ds.

CONTRIBUTORY (Secondary) Cholera Infantum
 (Duration) _____ yrs. _____ mos. 21 ds.
 (Signed) J. M. Finney M. D.
Aug 4 1918 (Address) Lafayette 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 Banks Chapel DATE OF BURIAL Aug 21 1918

20 UNDERTAKER A. R. Lutes ADDRESS Lutesville Mo

Revised United States Standard Certificate of Death

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

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21280-a
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.)