

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County Palk

Township _____

or Village Aldrich

or City _____

Registration District No. 700

File No. 14 32813

Primary Registration District No. 4421

Registered No. 14

(NO. _____ St. _____ Ward)

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

2 FULL NAME Clinton Hughes

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

16 DATE OF DEATH Sept - 12 - 1917
(Month) (Day) (Year)

6 DATE OF BIRTH March - 13 - 1835
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan - 8, 1917 to Sept - 12 - 1917 that I last saw him alive on July 10 - 1917 and that death occurred, on the date stated above, at 5:30 p m.

7 AGE 82 yrs. 5 mos. 29 ds. If LESS than 1 day.....hrs. or.....min.?

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
1917
1835
(Duration) 9 yrs. 9 mos. 9 ds.

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

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) W. T. Myron M. D. Sept - 13 - 1917 (Address) Aldrich Mo

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

PARENTS 10 NAME OF FATHER Len Hughes 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio 12 MAIDEN NAME OF MOTHER Miriam Stock 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

*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 _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ina Husky (Address) Aldrich Mo.

19 PLACE OF BURIAL OR REMOVAL Pleasant Ridge Cemetery DATE OF BURIAL Sept - 13 - 1917 20 UNDERTAKER Yakow Bros ADDRESS Aldrich Mo

15 Filed Sept 13, 1917 E. B. Moore 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*, *Composer*, *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.)

1 PLACE OF DEATH

County *Admck*

Township

Village

City

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

Registration District No. *700*

Primary Registration District No. *4471*

(NO.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No.

Registered No. *14*

St. Ward

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

2 FULL NAME

Clifton Hughes

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

(Month) (Day) 1 (Year)

7 AGE

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)

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 *11-9* 191*7* *E. E. Moore*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 12 191*7*

17 I HEREBY CERTIFY, that I attended deceased from

191 to 191

that I last saw h... alive on 191

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

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
64 (Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

a fall on ice (Duration) 3 yrs. mos. ds.

(Signed)

M. D. Myers M. D. *Sept-12-1917* (Address) *Albion 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

191

20 UNDERTAKER

Walton Bras

ADDRESS

Albion Mo

Original file, date, 19

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

Revised United States Standard Certificate of Death

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

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