

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

1 PLACE OF DEATH
County Butler
Township Brownstown
or
Village
or
City

Registration District No. 87 File No. 7991
Primary Registration District No. 5729 Registered No. 7
St. Ward

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

2 FULL NAME James Gilbert Husky

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u>
6 DATE OF BIRTH <u>May 27 1917</u> (Month) (Day) (Year)		
7 AGE <u>10</u> yrs. <u>14</u> mos. ds.		If LESS than 1 day... hrs. or... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>child at home</u> (b) General nature of industry business, or establishment in which employed (or employer) <input checked="" type="checkbox"/>		
9 BIRTHPLACE (City or town, State of foreign country) <u>Butler Co Mo.</u>		
PARENTS	10 NAME OF FATHER <u>J. A. Husky</u>	
	11 BIRTHPLACE OF FATHER (City or town, State of foreign country) <u>Jefferson Co. Mo.</u>	
	12 MAIDEN NAME OF MOTHER <u>Maud May Wells</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State of foreign country) <u>J. Shannon Co. Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 27 1918, to May 27 1918, that I last saw him alive on never, 1918, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:
Ribbed
4415
108

(Duration) 5 yrs. 3 mos. 5 ds.

CONTRIBUTORY (Secondary) fractured
(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) H. White M. D.
3/27 1918 (Address) Fandaling

*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) J. A. Husky
(Address) Poplar Bluff Mo.

19 PLACE OF BURIAL OR REMOVAL Bay Spring Cem. DATE OF BURIAL May 28 1918

15 Filed 4/20 1918, M. M. Luce
Registrar

20 UNDERTAKER H. White ADDRESS Fandaling 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*, *Housekeeper*, 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*, *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.)

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

1 PLACE OF DEATH

County Butler
Township Bear Dam
or
Village
or
City

Registration District No. 87 File No.
Primary Registration District No. 5129 Registered No. 7
St. Ward

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

2 FULL NAME

Leuis Gilbert Husky

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) 1 (Year)
Satisfactory Information Supplied.

7 AGE If LESS than 1 day, hrs. or min.?
Satisfactory Information Supplied.

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

9 BIRTHPLACE (City or town, State or foreign country)
Satisfactory Information Supplied.

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)
Satisfactory Information Supplied.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)
Satisfactory Information Supplied.

15 Filed 4/20 1918 M. M. Lauer Registrar

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Mar 27 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied. to Satisfactory Information Supplied. 1918 that I last saw him alive on Satisfactory Information Supplied. 1918 and that death occurred, on the date stated above Satisfactory Information Supplied. 1918.

The CAUSE OF DEATH* was as follows:
Rubella
(Duration) 5 yrs. 7 mos. 5 ds.
Satisfactory Information Supplied.

CONTRIBUTOR (Secondary) LABOR PNEUMONIA
(Duration) 7 yrs. 7 mos. 7 ds.
(Signed) Hewhite M. D.
7/10 1918 (Address) Fairdealng

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

At place of death (Duration) yrs. mos. ds. In the State (Duration) yrs. mos. ds.
Where disease contracted if not at place of death?
Former or usual residence
Satisfactory Information Supplied.

19 PLACE OF BURIAL OR REMOVAL Day Spring Cem. DATE OF BURIAL Mar 3/28 1918

20 UNDERTAKER Hawley ADDRESS Fairdealng Mo.

Revised United States Standard Certificate of Death

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

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799
"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *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 "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.)