

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

930

1. PLACE OF DEATH

County Howard Co.
Township Monstean
City (No. St. Ward)

Registration District No. 978
Primary Registration District No. 55-31

File No.
Registered No. 6-

2. FULL NAME

Fielding S. Mcguffey

(a) Residence No. St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17 1923

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 3 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shop worker
(b) General nature of industry, business, or establishment in which employed (or employer) R R Shop
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Boone Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Geo. Mcguffey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Roland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT G S Mcguffey
(Address) Harrisburg Mo.

15. FILED 2/10 1928 V. C. Bonham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1928 to Jan 17 1928 that I last saw him alive on Jan 17 1928, and the death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82D
paralysis
(duration) yrs. mos. 2 da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

Did an operation precede death? DATE OF

Was there an autopsy?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) S. G. Gullett M. D.
Harrisburg Mo. 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Harrisburg Mo. Jan 18 1928

20. UNDERTAKER R. L. Beasley ADDRESS Harrisburg Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH
 County..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... St.....

2. FULL NAME.....
 (a) Residence, No....., St....., Ward.....
 (Usual place of abode).....
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... **4. COLOR OR RACE**..... **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)
6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 SA. IF MARRIED, WIDOWED, OR DIVORCED (OR) HUSBAND OR WIFE OF.....
 Length of marriage in city or town where death occurred yrs. mos. da.

7. AGE YEARS MONTHS DAYS
 IF LESS THAN 1 day, hrs. min.
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work..... yrs. mos.
 (b) General nature of industry, business, or establishment in which employed (or employer)..... yrs. mos.
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
 (STATE OR COUNTRY)
10. NAME OF FATHER.....
 (STATE OR COUNTRY)
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER.....
 (STATE OR COUNTRY)
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
 (STATE OR COUNTRY)
14. INFORMANT.....
 (Address).....

15. FILED....., 19.....
 REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)
17. I HEREBY CERTIFY, That I attended deceased from.....
 that I last saw h....., 19....., to.....
 death occurred, on the date stated above, at.....
THE CAUSE OF DEATH* WAS AS FOLLOWS:
 CONTRIBUTORY..... yrs. mos.
 (SECONDARY).....
 (SIGNED)..... yrs. mos.
18. WHERE WAS DISEASE CONTRACTED
 *IF NOT AT PLACE OF DEATH..... DATE OF.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed).....
 , 19 (Address)
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE (1) MANNER AND NATURE OF INJURY, and (2) WHETHER ACCIDENTAL, SELF-HOMICIDE. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BI.....
20. UNDERTAKER..... ADDRESS.....

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, 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," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.