

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

1931

**1. PLACE OF DEATH**

County Morgan Registration District No. 557 File No. 3  
 Township Marian Primary Registration District No. 5752-a Registered No. 557  
 City                      (No.                     ) St.                      Ward                     

**2. FULL NAME** Robert L. Ruffigione

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Husband</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>                    </u>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, <u>                    </u> hrs. or <u>                    </u> min.	
<u>67</u>		<u>3</u>	<u>20</u>		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u> (c) Name of employer <u>                    </u>					

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/1 1923

17. I HEREBY CERTIFY, That I attended deceased from 12/25 1922, to 12/31 1922, that I last saw                      alive on 12/30 1922, and that death occurred, on the date stated above, at                      A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia  
                      
                      
 (duration)                      yrs.                      mos.                      da.

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

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) H. E. Shelton, M. D.  
 , 19                      (Address) Eldon mo

\*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.)

9. BIRTHPLACE (CITY OR TOWN)                       
 (STATE OR COUNTRY) Monroe Co. mo

PARENTS

10. NAME OF FATHER <u>John Ruffigione</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>mo.</u>
12. MAIDEN NAME OF MOTHER <u>Ann McDaniel</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>mo</u>

14. INFORMANT N. A. Gawes  
 (Address) Barnett mo

15. FILED 2/5 1923 R. J. Hatter  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL                      DATE OF BURIAL 1/2 1923  
Greenidge

20. UNDERTAKER N. A. Gawes ADDRESS Barnett mo.

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.

# 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, 8 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 symptomatic), "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.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Age not fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state sex, sex of it may be properly classified. Exact statement of OCCUPATION is very on back of certificate.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

599  
5792 a

1 PLACE OF DEATH

County Morgan  
Township Marian  
Village \_\_\_\_\_  
City \_\_\_\_\_

State of \_\_\_\_\_

Registered No. \_\_\_\_\_

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

2 FULL NAME

Robert L. Tiptigrove

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Jan 1, 1923  
(Month) (Day) (Year)

6 DATE OF BIRTH: \_\_\_\_\_, 19\_\_\_\_, \_\_\_\_\_  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. ?

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

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 (State or country) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

10 NAME OF FATHER \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_

11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

13 BIRTHPLACE OF MOTHER (State or country) \_\_\_\_\_

\_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_

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 \_\_\_\_\_, 19\_\_\_\_

15 Filed 2/5 1923 R. S. Hatter  
REGISTRAR

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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