

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

1927

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

1 PLACE OF DEATH
County Madison
Township _____
or _____
Village German
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. _____ File No. 800
Primary Registration District No. 5728 Registered No. _____

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

2 FULL NAME Charles Stucky

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>Single</u>
6 DATE OF BIRTH <u>June 7 1927</u> (Month) (Day) (Year)		
7 AGE <u>7</u> yrs. <u>6</u> mos. <u>10</u> ds.		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) <u>Madison Co.</u>		
PARENTS	10 NAME OF FATHER <u>Benj Stucky</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>out of state</u>	
	12 MAIDEN NAME OF MOTHER <u>Ilo Gross</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jan 14 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 7 1927 to Jan 14 1927 that I last saw him alive on Jan 13 1927 and that death occurred, on the date stated above at 2:15 p.m.

The CAUSE OF DEATH* was as follows:
Haemorrhage tooth
69 (Duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Haemiplegia
(Duration) yrs. mos. ds.
(Signed) J. C. Slough M. D.
(Address) Fredericktown 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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj Stucky
(Address) Fredericktown Mo.

15 Filed 1/1 1927 C. H. Davis M.D.
Registrar

19 PLACE OF BURIAL OR REMOVAL
Christian Cemetery

20 UNDERTAKER
Ed. A. Webb

DATE OF BURIAL
Jan 15 1927

ADDRESS
Fredericktown 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*, *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 who are engaged in the duties of the household (as *Housekeepers* who receive a definite salary), or 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," "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**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Madison Registration District No. 539 File No. 5
 Township _____ Primary Registration District No. 57/26 Registered No. _____
 City Herman (No. _____) St. _____ Ward _____

2. FULL NAME Charles Stecky
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17, 1920

7. AGE YEARS 10 MONTHS 10 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 14, 1927

17. HEREBY CERTIFY That I attended deceased from Jan 7 1927 to Jan 14 1927 that I last saw him alive on Jan 13 1927, and that death occurred, on the date stated above, at 2:15 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Septicæmia from tooth

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

9. BIRTHPLACE (CITY OR TOWN) Madison (STATE OR COUNTRY)

10. NAME OF FATHER Ben Stecky

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

12. MAIDEN NAME OF MOTHER Doc Groesbeck

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

14. INFORMANT Ben Stecky (Address) Fredericktown, Mo.

15. April 1, 1927 M. Carr REGISTRAR

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) St. Slaughter, M. D.
Jan 27 (Address) Fredericktown, 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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL R. Christian Cemetery DATE OF BURIAL Jan 15 1927

20. UNDERTAKER Ed. H. Kehl ADDRESS Fredericktown, Mo.

EXACTLY. PHYSICIANS should be properly classified. Exact state of OCCUPATION is very important. REGISTERS SHALL NOT RECEIVE A CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

ELEMENT

52130

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