

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

36192

1. PLACE OF DEATH

County Butler
Township Nuliyath
City ✓

Registration District No. 88
Primary Registration District No. 5-130

File No. _____
Registered No. 40
St. _____ Ward _____

2. FULL NAME

Gilbert Wesley Shickler

(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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 29 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
11 11 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work child at home
(b) General nature of industry, business, or establishment in which employed (or employer) home
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Butler co mo
(STATE OR COUNTRY)

10. NAME OF FATHER W. A. Shickler

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

12. MAIDEN NAME OF MOTHER Kate C. O. Long

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

14. INFORMANT W. A. Shickler
(Address) Harrisville, Mo.

15. FILED Nov 29 1928 R. L. Turner
REGISTRAR

✓ MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 1928

17. I HEREBY CERTIFY, That I attended deceased from October 24, 1928 to November 1, 1928 that I last saw him alive on Oct 28, 1928, and that death occurred, on the date stated above, at 12:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis
10/8
CONTRIBUTORY (SECONDARY) Typhoid fever
(duration) _____ yrs. mos. 3 ds.
(duration) _____ yrs. mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH... ✓

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS direct

(Signed) W. A. Shickler, M. D.

Nov 2, 1928 (Address) Harrisville 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

Harris Ridge

DATE OF BURIAL

Nov 2 1928

20. UNDERTAKER

Wm. W. Kelly

ADDRESS

Wm. W. Kelly

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.

Revised United States Standard Certificate of Death

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

Place of Occupation.—Precise statement of very important, so that the relative of various pursuits can be known. The lies to each and every person, irrespec- For many occupations a single word or first line will be sufficient, e. g., *Farmer* or *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Stationary fireman*, etc. cases, especially in industrial employ- necessary to know (a) the kind of work the nature of the business or industry, e an additional line is provided for the ent; it should be used only when needed.

(a) *Spinner*, (b) *Cotton mill*; (a) *Sales-ocery*; (a) *Foreman*, (b) *Automobile fac- naterial worked on may form part of the ment. Never return "Laborer," "Fore- nager," "Dealer,"* etc., without more fication, as *Day laborer*, *Farm laborer*, *Coal mine*, etc. Women at home, who are the duties of the household only (not paid rs who receive a definite salary), may be *Housewife*, *Housework* or *At home*, and ot gainfully employed, as *At school* or *At re* should be taken to report specifically ations of persons engaged in domestic wages, as *Servant*, *Cook*, *Housemaid*, etc.

If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupa- tion at beginning of illness. If retired from busi- ness, that fact may be indicated thus: *Farmer (re- tired, 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*; *Broncho- pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name ori- gin; "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 im- portant. 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," "Convul- sions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hem- orrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child- birth 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 rail- way 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 undesir- able 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, hemor- rhage, 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.