

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

10241

**1. PLACE OF DEATH**

County Issaquena Registration District No. 316 File No. \_\_\_\_\_  
 Township Boone Primary Registration District No. 4191 Registered No. 9  
 City Ash Grove (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Carl William Scritchfield  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-4-1929

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

17. I HEREBY CERTIFY, That I attended deceased from 3-1-1929, to 3-3-1929, that I last saw him alive on 3-3-1929, and that death occurred, on the date stated above, at 12:10 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-14-1929

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 21

Bilateral Broncho Pneumonia

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work infant  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

107 H (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

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

9. BIRTHPLACE (CITY OR TOWN) Ash Grove Mo. (STATE OR COUNTRY)

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

PARENTS

10. NAME OF FATHER Albert Scritchfield

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) near Mt Vernon Mo (STATE OR COUNTRY)

20. WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Jess Yates

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

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

(Signed) Charles H. McTaffie M.D.

3-4-1929 (Address) Ash Grove 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.)

14. INFORMANT Albert Scritchfield (Address) Ash Grove Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kelley cemetery DATE OF BURIAL 3-4-1929

15. FILED 4/8-29 Dr. Charles H. Orr REGISTRAR

20. UNDERTAKER none ADDRESS \_\_\_\_\_

Exact statement of OCCURRENCE IS VERY IMPORTANT. Exact statement of OCCURRENCE IS VERY IMPORTANT. Exact statement of OCCURRENCE IS VERY IMPORTANT.

929

# 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 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 neoplasma); *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," "Anomia" (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.

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Greene Registration District No. 316 File No. 10241  
 Township Park Grove Primary Registration District No. 4191 Registered No. 9  
 City Park Grove (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Carl William Scritchfield  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-4-1929

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bilateral Broncho  
Pneumonia

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

CONTRIBUTORY (SECONDARY) unknown  
 (duration) \_\_\_\_\_ yrs. mos. ds.

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 \_\_\_\_\_

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) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_  
 12. MAIDEN NAME OF MOTHER \_\_\_\_\_  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

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

15. FILED 6/19/29 Dr. Charles H. Orr  
 REGISTRAR

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

SUPPLEMENTARY

REGIS. 35 N. T. RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

S-10241