

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

22503

1. PLACE OF DEATH

County... Wynoids Registration District No. 746 File No.
 Township... Carroll Primary Registration District No. 5782 Registered No.
 City... (No. 1779) St. Ward

2. FULL NAME

Charley White

(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 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) 1-21-1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
22 5 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming
 (b) General nature of industry, business, or establishment in which employed (or employer): farm work
 (c) Name of employer: himself

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

10. NAME OF FATHER Dave White

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

12. MAIDEN NAME OF MOTHER Etta Boyd

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

14. INFORMANT Wm White (Address) Ellington, Mo

15. FILED 7/10, 1931 Essie Evans REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 27 1931

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1931, to June 27, 1931, that I last saw him alive on June 7 1/2 P, 1931, and that death occurred, on the date stated above, at 4 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY) Tuberculosis of Larynx

18. WHERE WAS DISEASE CONTRACTED (IF NOT AT PLACE OF DEATH) Stoddard Co. Mo

DID AN OPERATION PRECEDE DEATH? no DATE OF ... WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examination of sputum (Signed) A. F. BIGG, M. D.

6/28, 1931 (Address) Ellington, 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 Mooney Cemetery DATE OF BURIAL June 28 1931

20. UNDERTAKER Robert Clements ADDRESS Ellington,

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, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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, septicaemia, 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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Reynolds
Township Carroll
City Charley White (No. _____) St. _____ Ward _____

Registration District No. 746
Primary Registration District No. 5-979 B

File No. _____
Registered No. _____

2. FULL NAME

Charley White

(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>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>S</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 21 - 1909</u>		
7. AGE	YEARS <u>22</u>	MONTHS <u>5</u>
	DAYS <u>6</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farming</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Farm work</u>	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Madison Mo</u>		
FATHER	13. NAME <u>Dave White</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Madison Mo</u>	
MOTHER	15. MAIDEN NAME <u>Etta Days</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Madison Mo</u>	
17. INFORMANT <u>W. M. C. White</u> (ADDRESS) <u>Ellington Mo</u>		
18. BURIAL CREMATION, OR REMOVAL PLACE <u>Mooney Cem</u> DATE <u>June 28, 1931</u>		
19. UNDERTAKER <u>Robert Clements</u> (ADDRESS) <u>Ellington Mo</u>		
20. FILED <u>Aug 1</u> 19 <u>31</u> <u>L. B. Bombs</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 27, 1931

22. I HEREBY CERTIFY, That I attended deceased from Apr 15 - 1931 to June 27, 1931
I last saw him alive on June 7, 1931. Death is said to have occurred on the date stated above, at 4:50 p.m.
The principal cause of death and related causes of importance were as follows:
Pulmonary Tuberculosis Date of onset 10 mo
Other contributory causes of importance:
Tuberculosis of Lung 2 mo

Name of operation: no Date of _____
What test confirmed diagnosis? Examination of sputum Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) A. J. Aug 9 M. D.
(Address) Ellington Mo

STARS SHALL NOT RECEIVE A FEE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-22503