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

PLACE OF DEATH

County Wayne

Township Williams or Village ____ or City ____ (NO. ____ St. ____ Ward)

Registration District No. 892 File No. 32687-6

Primary Registration District No. 6193 ~~7541~~ Registered No. 23

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

FULL NAME Flemington Wells McGhee

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Divorce from 2d wife

DATE OF BIRTH: April (Month) 13 (Day), 1847 (Year)

AGE: 68 yrs. 5 mos. 18 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer and Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Owned farm

BIRTHPLACE (City or town, State or foreign country): Tenn

PARENTS

NAME OF FATHER: Calvin W. McGhee

BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Knows

MAIDEN NAME OF MOTHER: Amanda Caroline Wells

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. W. McGhee (son of deed)

(ADDRESS) Williamsville Mo

Filed ____, 191__. ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 1st (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 25, 1915, to Sept 30, 1915, that I last saw him alive on Sept 30, 1915, and that death occurred, on the date stated above, at 6 25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
82 A
82 D

(Duration) — yrs. — mos. 7 ds.

Contributory (Secondary) Paralysis (Duration) ____ yrs. ____ mos. 7 ds.

(Signed) J. P Sebastian M. D.

Oct 2d 191 6 (Address) Williamsville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 ____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Patterson Cem.	Oct 3, 1915
UNDERTAKER	**ADDRESS**
None	

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

PLACE OF DEATH

County.................

Township .... Registration District No.................. File No.................

or

Village................. Primary Registration District No.................. Registered No.................

or

City .... (NO. ...., ... St.; .... Ward) [If death occurred in hospital or institutic give its NAME inste of street and number]

FULL NAME.................

PERSONAL AND STATISTICAL PARTICULARS		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)
DATE OF BIRTH .... (Month) .... (Day), 1...... (Year)		
AGE .... yrs. .... mos. .... ds.		If LESS than 1 day, ...hrs. or ......min.?
OCCUPATION (a) Trade, profession, or particular kind of work		
(b) General nature of Industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country)		
PARENTS — NAME OF FATHER		
PARENTS — BIRTHPLACE OF FATHER (City or town, State or foreign country)		
PARENTS — MAIDEN NAME OF MOTHER		
PARENTS — BIRTHPLACE OF MOTHER (City or town, State or foreign country)		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).................

(ADDRESS).................

Filed ...., 191....., ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH .... (Month) .... (Day), 191... (Year)

I HEREBY CERTIFY, that I attended deceased from ...., 191......, to ...., 191...

that I last saw h...... alive on ...., 191...

and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

....

....

.... (Duration) .... yrs. .... mos. .... ds.

Contributory .... (SECONDARY)

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) .... M. D.

................., 191...... (Address).................

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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.................

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ...., 191.....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WI[illegible] INK—THIS IS A [illegible]

[illegible] should be carefully [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1 PLACE OF DEATH

County Platte

Township Williams

or

Village .....

or

City ..... (No. ..... St. ..... Ward)

Registration District No. 894

Primary Registration District No. 6193

File No. .....

Registered No. 23

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

2 FULL NAME Flannigan Hills McGhee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) D

6 DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7 AGE ..... yrs. ..... mos. ..... 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)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 Filed Jan 20, 1916 J. L. McGhee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) Oct (Day) 1 (Year) 15

17 I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191...,
that I last saw h... alive on ....., 191...,
and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191...

20 UNDERTAKER None

ADDRESS

Original file, date Oct 7, 1915

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

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, 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, peritonaeum*, 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), *29ds.; 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 *septichaemia*," "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.)