

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

PLACE OF DEATH

County Clay  
Township Gallatin  
or  
Village Randolph  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 197 File No. 37433  
Primary Registration District No. 5276 Registered No. 17

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

FULL NAME Albert Wingfield

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)

DATE OF BIRTH 12-26-1867  
(Month) (Day) (Year)

AGE 42 yrs. 11 mos. 27 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

BIRTHPLACE (City or town, State or foreign country) Macon City Mo

PARENTS  
NAME OF FATHER Thomas Wingfield  
BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
MAIDEN NAME OF MOTHER Irene Hickerson  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Wingfield  
(ADDRESS) Randolph Mo

Filed 12/25 1910 R. A. [Signature]  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12-23 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from December 17, 1910, to Dec. 23, 1910, that I last saw him alive on Dec 22, 1910, and that death occurred, on the date stated above, at 12:30 m. The CAUSE OF DEATH\* was as follows:

Pleura Pulmonaria

100 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) T. J. Ward M. D.  
Dec 24 1910 (Address) Birmingham 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 Minerville Mo DATE OF BURIAL 12/25 1910

UNDERTAKER no undertaker ADDRESS \_\_\_\_\_

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.

**PLACE OF DEATH**

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

County \_\_\_\_\_  
 Township \_\_\_\_\_ or \_\_\_\_\_  
 Village \_\_\_\_\_ or \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_  
 Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead 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) _____ (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) _____	

**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)

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*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
UNDERTAKER	ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed \_\_\_\_\_, 191\_\_\_\_

REGISTRAR

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.

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.

PLACE OF DEATH  
 County Clay  
 Township Walden  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

CERTIFICATE OF DEATH

Registration District No. 799 1917 File No. 37433  
 Primary Registration District No. 5276 Registered No. 17-

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

FULL NAME Albert Wingfield

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOW OR DIVORCED married  
(Write the word)  
 DATE OF BIRTH 12-26, 1867  
(Month) (Day) (Year)  
 AGE 42 yrs. 11 mos. 27 ds. IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?  
 OCCUPATION (a) Trade, profession, or particular kind of work Carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer) Railroad

BIRTHPLACE (City or town, State or foreign country) Macon City, Mo.

PARENTS  
 NAME OF FATHER Thos. Wingfield  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky  
 MAIDEN NAME OF MOTHER Irene Jackson  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Annie Wingfield

(ADDRESS) Randolph, Mo.

Filed 12/26 1917 9th Ward REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12-23, 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12/17, 1910, to 12/23, 1910, that I last saw alive on 12/22, 1910, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH\* was as follows:

Pneumonia-Pneumonia  
 (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 10 ds.

Contributory (SECONDARY) (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) T. J. Ward M. D. 12/24, 1910 (Address) Birmingham, Ala.

\*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 Memorville, Mo. DATE OF BURIAL 12/25, 1910  
 UNDERTAKER None ADDRESS \_\_\_\_\_

DEC

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

# 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*, *peritoneum*, etc., *Carcinoma*, *Sar-*

*coma*, 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.)