

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

5551

1 PLACE OF DEATH

County Newton
Township Benton
or
Village
or
City (NO. _____) (St. _____) (Ward _____)

Registration District No. 142 File No. _____

Primary Registration District No. 6264 Registered No. 4

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

2 FULL NAME

Charles Ed Laugherty

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE Married
MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH July 12 1885
(Month) (Day) (Year)

7 AGE 30 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS
10 NAME OF FATHER Preston Laugherty
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
12 MAIDEN NAME OF MOTHER Mary Kirches
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Laugherty
(Address) Newton Mo. N 2.

15 Filed Feb. 25 1915 E. Edmondson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 23 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb. 21, 1915 to Feb. 23, 1915
that I last saw him alive on Feb. 23, 1915
and that death occurred, on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

30 Mening.
130

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

CONTRIBUTORY (Secondary) Tuberculosis
(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) J. P. Edmondson M. D.
Feb. 25, 1915 (Address) Stella Mo.

*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 Hazel Green DATE OF BURIAL Feb. 25 1915

20 UNDERTAKER J. P. Pogue ADDRESS Stella Mo.

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, 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), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Con- genital*," "*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.)

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

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4

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

FULL NAME

Charles E. Daugherty

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

M

COLOR OR RACE

W

SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)

M

DATE OF DEATH

Feb - 24, 191*5*
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

Yrs. mos. ds.

If LESS than 1 day, hrs. or min.

I HEREBY CERTIFY, that I attended deceased from *Satisfactory* information supplied, 191*5*, that I last saw h *alive on* 191*5*

and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Acute nephritis, probable
tuberculosis of kidney
(Duration) yrs. mos. ds.

Contributor *tuberculosis*
(Secondary) (Duration) yrs. mos. ds.

(Signed) *J. L. Edmondson* M. D.
725 191*5* (Address) *Stella* *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 191*5*

UNDERTAKER ADDRESS

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)

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

725 191*5* *J. L. Edmondson* REGISTRAR

Original file, date

Feb - 25 191*5*

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full. Statement of OCCUPATION is very important.

Satisfactory information supplied

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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