

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

PLACE OF DEATH

County Newton

Township Newtonia

Village _____

City _____

Registration District No. 610

Primary Registration District No. 5811

File No. _____

Registered No. _____

38971

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

FULL NAME Bergel Wright

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE Color SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)

DATE OF BIRTH Sept 3, 1916
(Month) (Day) (Year)

AGE 1 yrs. 2 mos. 24 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 Jean Davis

BIRTHPLACE OF FATHER Don't know
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Ira Wright

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Wright

(ADDRESS) Newtonia Mo

Filed Nov 28, 1917

J. B. Hancock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 27, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 22, 1917, to _____, 191____, that I last saw him alive on Nov 22, 1917, and that death occurred, on the date stated above, at 4 1/2 m. The CAUSE OF DEATH* was as follows:

Solar Pneumonia
108

(Duration) 9 mos. 5 ds.

Contributory

(SECONDARY)

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

(Signed) J. B. Hancock M. D.

Nov 28, 1917 (Address) Newtonia 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 Newtonia Mo

DATE OF BURIAL Nov 28, 1917

UNDERTAKER White & Rogers

ADDRESS Fairview Mo

INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should be carefully classified. Exact statement of OCCUPATION is very important.

USE OF DEATH in plain terms, so that it may be understood.

PLACE OF DEATH

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

County _____
 Township _____ or _____
 Village _____ or _____
 City _____ (NO. _____)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____
 (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) _____
 IF LESS than 1 day, _____ hrs. _____ min.?
 _____ yrs. _____ mos. _____ ds.

AGE _____
 IF LESS than 1 day, _____ hrs. _____ min.?
 _____ yrs. _____ mos. _____ ds.

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)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (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:

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)

Contributory
(SECONDARY)

(Signed) _____, 191____ (Address) _____ M. D. _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Duration) _____ yrs. _____ mos. _____ ds.

*State the Disease Causing Death, or, in deaths from Violent Causes, size of (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) _____ yrs. _____ mos. _____ ds. in the _____ State _____ yrs. _____ mos. _____ ds. At place of death. Where was disease contracted if not at place of death? Former or usual residence.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 (ADDRESS) _____
 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____
 UNDERTAKER _____ ADDRESS _____
 REGISTRAR _____

Filed _____, 191____

AINLY, WITH UNFADING INK

It is of information should be carefully supplied. A
 OF DEATH in plain terms, so that it may be properly of

IAN



WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B. - If location of death is in city, with population less than 100,000, and is not a hospital, institution, or place of confinement, the name of the physician or physicians should be stated EXACTLY. PHYSICIANS & WHO. If state is not given, give county. If age is not given, give age. If sex is not given, give sex. If occupation is not given, give occupation. If cause of death is not given, give cause of death. If date of death is not given, give date of death. If time of death is not given, give time of death. If sex is not given, give sex. If race is not given, give race. If color is not given, give color. If marital status is not given, give marital status. If occupation is not given, give occupation. If cause of death is not given, give cause of death. If date of death is not given, give date of death. If time of death is not given, give time of death.

1 PLACE OF DEATH

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

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

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

Registration District No. 610 File No.
 Primary Registration District No. 5811 Registered No.

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

2 FULL NAME Virgil Wright Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE B 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.

6 DATE OF BIRTH
 (Month) (Day) (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) Newtonia, Mo. R. 2

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)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 27 1917
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191, that I last saw him 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 death 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 ADDRESS

Filed Nov 28 1917 J. B. Lane Registrar

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 *Nons.*

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 inter-current) 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 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.)