

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

PLACE OF DEATH

County Co. Barton
Township Brunswick
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 169 File No. 1 562
Primary Registration District No. 5235 Registered No. _____

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

FULL NAME Manson H. Wright

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>U</u> (Write the word)
DATE OF BIRTH <u>June 6</u> , 18 <u>83</u> (Month) (Day) (Year)		
AGE <u>84</u> yrs. <u>7</u> mos. <u>4</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>" " " "</u>		

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

PARENTS	NAME OF FATHER <u>Wm C. Wright</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mass Burgz</u>
	MAIDEN NAME OF MOTHER <u>Kentucky</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo W. Wright
(ADDRESS) Brunswick, Mo
Filed July 10, 1918, Fanny E. Tatum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
July 10, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 7, 1918, to Jan 10, 1918, that I last saw him alive on Jan 7, 1918, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Semility
92A
162

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

Contributory (SECONDARY) _____

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

(Signed) R. P. Price M. D.
Jan 10, 1918 (Address) Triplett 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 <u>Salisbury, Mo</u>	DATE OF BURIAL <u>July 11</u> , 191 <u>8</u>
UNDERTAKER <u>L. Weisel</u>	ADDRESS <u>Brunswick</u>

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

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 a hospital or institution, give its NAME instead of street and number]

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

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, 191..... (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:

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)

PARENTS

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

(ADDRESS).....

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 Cause, 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

Filed, 191.....

REGISTRAR

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Chariton

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

Township

Brunswick

Registration District No.

169

File No.

1

Village

Primary Registration District No.

5235

Registered No.

City

(NO. St. Ward)

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

2 FULL NAME

Mason N. Wright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *W*

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

7 AGE 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)

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)

FILED

Jan 10 1918 Harry E. Jatum Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 10 1918*

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:

Semity with Chronic Valvular Disease of Heart

CONTRIBUTORY (Secondary)

(Signed) *R. P. Price* 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

20 UNDERTAKER

ADDRESS

Original file, date

Jan 10 1918

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*; *Broncho-pneumonia* ("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 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.)

295