

Do not use this space.

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

3571 <sup>a</sup>**1. PLACE OF DEATH**County StoddardRegistration District No. 888 839

File No. \_\_\_\_\_

Township RichlandPrimary Registration District No. 6101Registered No. 15

City \_\_\_\_\_ (No. \_\_\_\_\_) \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Stoddard County  
(STATE OR COUNTRY) Missouri10. NAME OF FATHER Callie Grubb11. BIRTHPLACE OF FATHER (CITY OR TOWN) Indiana  
(STATE OR COUNTRY) \_\_\_\_\_12. MAIDEN NAME OF MOTHER Pearl Ellis13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Indiana  
(STATE OR COUNTRY) \_\_\_\_\_14. INFORMANT Callie Grubb  
(Address) East 7<sup>th</sup> & Lake15. FILED 5/1 1926 L. J. Baker  
REGISTRAR**MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 192617. I HEREBY CERTIFY That I attended deceased from Dec 17 1925 to Jan 17 1926 that I last saw him alive on Jan 16 1926 and that death occurred, on the date stated above, at 4 A. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

chronic malarial feverCONTRIBUTOR (SECONDARY) 5 (duration) yrs. 1 mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? clinical symptoms(Signed) D. L. Bennett, M. D., 1926 (Address) Dexter - Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSED, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Taylor Cemetery DATE OF BURIAL 1-18 192620. UNDERTAKER COOPER ADDRESS Dexter Mo.

CAUSE OF DEATH IN THIS SPACE SHOULD BE EXACTLY AS OCCUPATION IS VERY IMPORTANT.

# 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* (avoid use of "Typhoid 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 neoplasm); *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENT  
BY PHYSICIAN.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Stoddard Registration District No. 839 File No. 2575  
 Township Richland Primary Registration District No. 6101 Registered On 2575  
 City (No. ....) (St. .... Ward)

**2. FULL NAME**

Glenn Gubb

(a) Residence No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) —

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1926

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

17. I HEREBY CERTIFY that I attended deceased from Dec 17 1925 to Jan 17 1926 and that I last saw him on Jan 16 1926 and that death occurred, on the date stated above, at 4 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

(Chronic) malarial fever

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) .... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....  
 (c) Name of employer .....

**CONTRIBUTORY (SECONDARY)**

9. BIRTHPLACE (CITY OR TOWN) Stoddard County Missouri  
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

10. NAME OF FATHER Callie Gubb

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Indiana  
 (STATE OR COUNTRY)

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms

12. MAIDEN NAME OF MOTHER Callie Gubb

(Signed) C. R. Bennett, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Indiana  
 (STATE OR COUNTRY)

(Address) 211 1916 Dexter, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT Callie Gubb  
 (Address) Essex

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wayton Cemetery DATE OF BURIAL 1/18 1926

15. FILED 6/7 1926 H. C. Calder  
 REGISTRAR

20. UNDERTAKER W. O. Briggs ADDRESS Dexter, Mo.

SUPPLEMENTARY

LAW DATES UNTIL THEY ARE COMPLETE AS PREC CAUSE OF DEATH INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGP. BE STATED BY CLERKS SHOULD AT ALL TIMES BE PROPERLY CLEAR.

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5-3571A  
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