

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.

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

PLACE OF DEATH
County Dallas
Township West Point
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 49 File No. 4177
Primary Registration District No. 5073 Registered No. 1

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

FULL NAME John Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>Swedish</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>February 23, 1895</u> (Month) (Day) (Year)		
AGE <u>75</u> yrs. <u>1</u> mos. <u>1</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired 5 years</u>		
BIRTHPLACE <u>Kalmar</u> (City or town, State or foreign country) <u>Sweden</u>		
PARENTS	NAME OF FATHER <u>Andrew Anderson</u>	
	BIRTHPLACE OF FATHER <u>Sweden</u> (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER <u>Sophia Sundquist</u>	
	BIRTHPLACE OF MOTHER <u>Kalmar</u> (City or town, State or foreign country) <u>Sweden</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Sundquist
Amsterdam Mo.
(ADDRESS)

Filed 3/25/10 1910

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 24, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I observed deceased from died unattended, 1910,
that I last saw him alive on, 1910,
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Contributory (SECONDARY)
(Duration) 3 yrs. 3 mos. 0 ds.
(Signed) C. J. Martin Registrar
(Address) Register

*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
Scott's Cemetary

DATE OF BURIAL
3/ 25-1910 1910

UNDERTAKER

ADDRESS

Geo. V. Bassett

Amsterdam

Revised United States Standard Certificate of Death

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

Statement of occupation.—Precise occupation is very important, so that the fullness of various pursuits can be known applies to each and every person of age. For many occupations a single word on the first line will be sufficient, e. g., *Farmer*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. In many cases, especially in industrial employment, it is necessary to know (a) the kind of work, the nature of the business or industry, and (b) the additional line is provided for the latter purpose. It should be used only when needed. *Examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocer; (a) Foreman, (b) Automobile factory.* For those who worked on may form part of the statement. Never return "Laborer," "Foreman," "Dealer," etc., without more precise statement. *Examples: Day laborer, Farm laborer, Laborer—Women at home, who are engaged in household only (not paid Housekeeper), may be entered as Household worker, or At home, and children, not engaged, 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 on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired, that fact may be indicated thus: *Retired, 6 yrs.* For persons who have no occupation, write *None*.

Statement of cause of death.—The DISEASE CAUSING DEATH (the primary action with respect to time and causation), using the same accepted term for the same disease. *Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria ("Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.; Cholera, Sar-*

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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.)

