

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.

PLACE OF DEATH *Not certified*

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

County *Stoddard* Registration District No. *839*
Hubland File No. *36631*

Township _____ or Village _____ Primary Registration District No. *6070* Registered No. _____
or City _____ (NO. _____) St. _____ Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>Male</i>	COLOR OR RACE <i>White</i>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Married</i>
DATE OF BIRTH <i>1940 20 1849</i> (Month) (Day) (Year)		
AGE <i>61 yrs. 10 mos. 30 ds.</i>		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <i>Fanner 13211</i>		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>Filling the Soil</i>		
BIRTHPLACE (City or town, State or foreign country) <i>Ind.</i>		
PARENTS	NAME OF FATHER <i>Rayman Gausler</i>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) —	
	MAIDEN NAME OF MOTHER <i>Anna Hadley</i>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) —	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) <i>Wesley Hutchason</i>		
(ADDRESS) <i>Delton Mo</i>		
Filed <i>11-30</i> 191 <i>0</i> <i>J. A. Milner</i> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Nov 6*, 191*0*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Oct 27*, 191*0*, to *Nov 6*, 191*0*, that I last saw him alive on *Nov 6*, 191*0*, and that death occurred, on the date stated above, at *11:45 Am.*

The CAUSE OF DEATH* was as follows:
*13211 Hypertrophy of Liver
with nephritis associated
with inflammation
of joints*

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

(Signed) *W. Miller* M. D.
Nov 9, 191*0* (Address) *Delton 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 <i>Delton</i>	DATE OF BURIAL <i>Nov 9</i> , 191 <i>0</i>
UNDERTAKER	ADDRESS

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*, *Composer*, *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*, *Sar-*

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.)



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PLACE OF DEATH

County Stoddard
Township Richland
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
Registration District No. 839

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No. 36631
Registered No. _____

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

FULL NAME Andrew Fansley

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Dec. 20</u> ¹⁸⁴⁹ (Month) (Day) (Year)		
AGE <u>61</u> yrs. <u>10</u> mos. <u>20</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>tilling the soil</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Ind.</u>		
PARENTS	NAME OF FATHER <u>Prof. Fansley</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER <u>Anna Sadley</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 8, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 27, 1910, to Nov. 8, 1910, that I last saw deceased on Nov. 8, 1910, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Spleen
Myocarditis Associated
with inflammation of
arteries (Duration) 1 yrs. _____ mos. _____ ds.

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

(Signed) J. V. Miller M. D.
11/9, 1910 (Address) Sikeston, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Herley Hutchason
(ADDRESS) Sikeston, Mo.

Filed 11/20, 1910, J. E. Caldwell
REGISTRAR

PLACE OF BURIAL OR REMOVAL, <u>Big Spring</u>	DATE OF BURIAL <u>11/9</u> , 191 <u>0</u>
UNDERTAKER <u>Had none</u>	ADDRESS _____

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]

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