

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

PLACE OF DEATH

County Bron
Township Arceadia
or Pilot Knob Mo
Village
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 392 File No. 10328
Primary Registration District No. 5546-13 Registered No. 9

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

FULL NAME Alvin Gude

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH April 2, 1892
(Month) (Day) (Year)
AGE 18 yrs. 11 mos. 24 ds. If LESS than 1 day, _____ hrs. or _____ min.?

DATE OF DEATH March 25, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911,

that I last saw him alive on _____, 1911, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Accidental death
3-29-11
18-11-24
(Duration) _____ yrs. _____ mos. _____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) general work

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

BIRTHPLACE (City or town, State or foreign country) Pilot Knob Mo

(Signed) Geo Farrar M. D.
March 29, 1911 (Address) Bron Mo

NAME OF FATHER Herman Gude

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF FATHER Marion Waider
(City or town, State or foreign country) Germany

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

MAIDEN NAME OF MOTHER Emma Will

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

BIRTHPLACE OF MOTHER Pilot Knob Mo.
(City or town, State or foreign country)

Where was disease contracted If not at place of death? _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Former or usual residence _____

(Informant) Herman Gude

PLACE OF BURIAL OR REMOVAL Pilot Knob Cemetery DATE OF BURIAL March 27, 1911

(ADDRESS) Pilot Knob Mo.

UNDERTAKER F. A. Ebrecht ADDRESS Pilot Knob

Filed March 30, 1911 John S. Luthy REGISTRAR

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.

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.)



PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Law
Township Archer
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 392 File No. 10328
Primary Registration District No. 5346^a Registered No. _____

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

FULL NAME Alvin Gude

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX _____ COLOR OR RACE _____ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH _____, 191____
(Month) 3 (Day) 25 (Year)

DATE OF BIRTH _____, 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.

AGE _____ yrs _____ mos _____ ds.
If LESS than 1 day, _____ hrs or _____ min.

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Accident
Killed in a mine by fall of rock.
(Duration) _____ yrs _____ mos _____ ds.

BIRTHPLACE (City or town, State or foreign country) _____

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

NAME OF FATHER _____

(Signed) G. W. Harnar M. D. _____, 191____ (Address) Fronton Mo

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

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

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) _____

At place of death _____ yrs _____ mos _____ ds. In the State _____ yrs _____ mos _____ ds.

(ADDRESS) _____

Where was disease contracted If not at place of death? _____

Filed _____, 191____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

REGISTRAR

SUPPLEMENTARY

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health
Association)

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