

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

PLACE OF DEATH
County Stoddard
Township Dunk Creek
or
Village _____
or
City Puxie Mo. (NO. _____) St.: _____ Ward _____

Registration District No. 840 File No. 13132
Primary Registration District No. 4511
6762 Registered No. _____

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

FULL NAME Doris Ola Anderson

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	
DATE OF BIRTH <u>2</u> (Month) <u>22</u> (Day) <u>1909</u> (Year)			
AGE <u>2</u> yrs. <u>0</u> mos. <u>26</u> 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) <u>0</u>			
BIRTHPLACE (City or town, State or foreign country) <u>Puxie</u>			
PARENTS	NAME OF FATHER <u>Herman Anderson</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Jackson Mo</u>		
	MAIDEN NAME OF MOTHER <u>Myrtle Lowery</u>		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>State of Ill.</u>		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>March</u> <u>18</u> , 19 <u>11</u> (Month) (Day) (Year)	I HEREBY CERTIFY, that I attended deceased from <u>3/15</u> , 19 <u>11</u> , to <u>3/18</u> , 19 <u>11</u> , that I last saw <u>her</u> alive on <u>3/18</u> , 19 <u>11</u> , and that death occurred, on the date stated above, at <u>5:00</u> m.
The CAUSE OF DEATH* was as follows: <u>Measles</u> <u>7</u> <u>6/1</u> (Duration) yrs. mos. ds.	
Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.	
(Signed) <u>James M. Page</u> M. D. <u>3/19/11</u> 19 <u>11</u> (Address) <u>Puxie Mo</u>	
*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) Herman Anderson
(ADDRESS) Puxie Mo
Filed Mar 19, 1911, L. B. Burrell
REGISTRAR

PLACE OF BURIAL OR REMOVAL _____	DATE OF BURIAL _____ 19 <u>11</u>
UNDERTAKER _____	ADDRESS _____

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.)



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Stoddard

Township _____

Village Cuxico Mo.

City _____

Registration District No. 840

Primary Registration District No. 4571

File No. 13132

Registered No. _____

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

FULL NAME

Lorris Ola Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF HAIR White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH 9 22 1909
(Month) (Day) (Year)

AGE 2 yrs 0 mos 26 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) _____

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

PARENTS NAME OF FATHER Herman Anderson BIRTHPLACE OF FATHER Cuxico, Mo. MAIDEN NAME OF MOTHER Martha Lowery BIRTHPLACE OF MOTHER State of Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Herman Anderson (ADDRESS) Cuxico Mo.

Filed Mar 19 1911 L. B. Burrell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 18 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3/18, 1911, to 3/18, 1911, that I last saw her alive on 3/18, 1911, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH was as follows: Measles

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

(Signed) J. M. Page M. D. 3/19 1911 (Address) Cuxico 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 Cuxico Cemetery DATE OF BURIAL Mar 19 1911

UNDERTAKER G. Heckman ADDRESS Cuxico Mo.

Revised United States Standard Certificate of Death

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

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