

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 Stone
 Township Galesburg
 or Washington
 Village _____
 or _____
 City Galesburg (NO. _____ St. _____ Ward _____)

Registration District No. 8 H 3 File No. 16669
 Primary Registration District No. 6106 Registered No. 23

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

FULL NAME Alpheus J Weaver

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---------------------|---|
| SEX _____ | COLOR OR RACE _____ | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
| DATE OF BIRTH _____ | | |
| (Month) <u>8</u> (Day) <u>29</u> (Year) <u>1881</u> | | |
| AGE _____ | | IF LESS than |
| <u>30</u> yrs. <u>7</u> mos. <u>17</u> ds. | | 1 day, _____ hrs. or _____ min.? |

OCCUPATION
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) 1-62

BIRTHPLACE
 (City or town, State or foreign country) Gostoria Ohio

| | |
|----------------|---|
| PARENTS | NAME OF FATHER <u>Alpheus Weaver</u> |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Illinois</u> |
| | MAIDEN NAME OF MOTHER <u>Rachel Patterson</u> |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Penn</u> |

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) George Laukin
 (ADDRESS) Galesburg Mo

Filed Apr 17th 1911 J M Cord
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
April 16, 1911
 (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.
 The CAUSE OF DEATH* was as follows:

169
Drowned by accident
153

Contributory _____
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ M. D.
 _____, 191____ (Address) _____

*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 <u>Shipped to Gostoria Ohio</u> | DATE OF BURIAL _____, 191____ |
| UNDERTAKER <u>R H Lile</u> | ADDRESS <u>Marionville Mo.</u> |

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"); *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

County St. Louis
 Township Washington
 or
 Village _____
 or
 City _____

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 843 File No. 16669

Primary Registration District No. 6106 Registered No. 99

No. _____ St. _____ Ward _____

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

FULL NAME

Alpheus J. Weaver

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

DATE OF BIRTH 8 (Month) 29 (Day) 1881 (Year)

AGE 130 yrs. 7 mos. 17 ds. If LESS than 1 day, ___ hrs or ___ min.

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

BIRTHPLACE (City or town, State or foreign country) Fostoria, Ohio

PARENTS

NAME OF FATHER Alpheus Weaver

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

MAIDEN NAME OF MOTHER W. Patterson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Lamkin
 (ADDRESS) Galena, Ill.

Filed April 17 1911 J. M. Cozad REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 16, 1911
 (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.

The CAUSE OF DEATH* was as follows:
drowned by accident

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

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

(Signed) No Doctor X M. D. X
 X (Address) _____ X

*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 Ship to Helena, Ark. DATE OF BURIAL Dec 1 1911 X

UNDERTAKER A. H. Hite ADDRESS Warrensburg, Mo.

Revised United States Standard Certificate of Death

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

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