

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 Jackson  
Township Prairie  
or ~~Village~~  
Village Little Star  
or  
City no (NO.)

Registration District No. 400 File No. 34868  
Primary Registration District No. 5553B Registered No. 65  
St.: \_\_\_\_\_ Ward: \_\_\_\_\_

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

**FULL NAME** William Franklin Rider

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Male COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH no record  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

AGE 59 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ 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) 1-01

BIRTHPLACE (City or town, State or foreign country) Jackson Co

NAME OF FATHER no record

BIRTHPLACE OF FATHER (City or town, State or foreign country) no record

MAIDEN NAME OF MOTHER no record

BIRTHPLACE OF MOTHER (City or town, State or foreign country) no record

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Harrison  
(ADDRESS) Little Star Mo

Filed Oct. 15 1911 A. Sweeney REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH 10-10-1911  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from 2-11-1911, to 10-14-1911, that I last saw him alive on 10-14-1911, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:  
Concussion of Brain

Contributory Cerebral Softening  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. Harrison M. D.  
10-15-1911 (Address) Little Star 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 59 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_

Where was disease contracted if not at place of death? no record

Former or usual residence Jackson Co

PLACE OF BURIAL OR REMOVAL Pruss Cemetery DATE OF BURIAL 10-15-1911

UNDERTAKER W. F. Adcock ADDRESS Little Star Mo

# 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.)



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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Jackson  
Township or Village or City Chairie

Registration District No. 400 File No. \_\_\_\_\_  
Primary Registration District No. 1537B Registered No. 65

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

FULL NAME Franklin Rider

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE  MARRIED  WIDOWED  OR DIVORCED   
(Write the word)

DATE OF BIRTH 10 month (Month) 10 (Day) 1911 (Year)

AGE 59 yrs. 0 mos. 0 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

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

BIRTHPLACE (City or town, State or foreign county) Jackson

PARENTS  
NAME OF FATHER W. Harrison  
BIRTHPLACE OF FATHER (City or town, State or foreign county)  
MAIDEN NAME OF MOTHER  
BIRTHPLACE OF MOTHER (City or town, State or foreign county)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) W. Harrison

Address 10-15-1911  
Filed Oct. 15 1911  
REGISTRAR W. Harrison

Original file, date Oct. 15 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 10-15, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1911, to 10-14, 1911, that I last saw h. alive on \_\_\_\_\_, 1911, and that death occurred, on the date stated above at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
My husband fell down Stairway  
(Duration) yrs. 0 mos. 0 ds.

Contributory (Secondarily) \_\_\_\_\_  
(Duration) yrs. 0 mos. 0 ds.  
(Signed) W. Harrison M. D.  
10-15-1911 (Address) 10-15-1911

\*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 1 yrs. 0 mos. 0 ds. In the 10 State 10 yrs. 0 mos. 0 ds.  
Where was disease contracted if not at place of death? Worcester  
Former or usual residence Jackson

PLACE OF BURIAL OR REMOVAL Worcester DATE OF BURIAL 10-15, 1911

UNDERTAKER W. Harrison ADDRESS \_\_\_\_\_

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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