

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.

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

PLACE OF DEATH
County Scott
Township Commerce - Registration District No. 847 File No. 12015
or
Village _____ Primary Registration District No. 6066 Registered No. 6
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Henry Adam Sanders

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Feb</u> <u>19</u> <u>1912</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>1</u> mos. <u>0</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> <u>9:00</u>		
(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>Scott Co Mo</u>		
PARENTS	NAME OF FATHER <u>Henry Sanders</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Scott Co Mo</u>	
	MAIDEN NAME OF MOTHER <u>Hueda Sanders</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scott Co Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar - 19 - 1912
(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:
Cause of death not known, I was found dead in bed this morning (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) Registrar 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Sanders
(ADDRESS) Commerce Mo

PLACE OF BURIAL OR REMOVAL Sanders Cem DATE OF BURIAL 3/20 1912

Filed Mar 19 1912 T. R. Frazer REGISTRAR

UNDERTAKER R. B. Hunkler ADDRESS Commerce

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.)



MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. All information 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 Scott
 County Scott
 Township Commerce
 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. 817 File No. 12015-
 Primary Registration District No. 6066 Registered No. 6

FULL NAME Henry Adam Saunders

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

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

DATE OF BIRTH Feb 19 1912
 (Month) (Day) (Year)

AGE _____ yrs. 1 mos. 1 ds. IF LESS than 1 day, _____ hr. or _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Scott Co Mo.

PARENTS

NAME OF FATHER <u>Henry Saunders</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Scott Co Mo.</u>
MAIDEN NAME OF MOTHER <u>Idella Saunders</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scott Co Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Henry Saunders
 (ADDRESS) Commerce Mo.

Filed 3/20 1912 by J.P. Frozer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 19 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1912, to _____, 1912, that I first saw him alive on _____, 1912, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
cause of death not known
was found dead in bed in the morning

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

Signed: J.P. Frozer M. D.
Mar 20 1912 (Address) Commerce 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 Saunders Co DATE OF BURIAL 3/26 1912

UNBERTAKER R.B. Humlan ADDRESS Commerce

Revised United States Standard Certificate of Death

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

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