

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.

PLACE OF DEATH
County Howard

Township _____
or
Village _____
or
City New Franklin (NO. _____ St. 2 Ward)

Registration District No. 380 File No. 13309
Primary Registration District No. 4224 Registered No. 9

FULL NAME Charles Carroll Alsop

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb. 25, 1855
(Month) (Day) (Year)

AGE 57 yrs. 15 mos. 15 ds. IF LESS than
1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 403rd

BIRTHPLACE
(City or town, State or foreign country) New Franklin

PARENTS
NAME OF FATHER Elliott Alsop
BIRTHPLACE OF FATHER New Franklin
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Julia Gurner
BIRTHPLACE OF MOTHER New Franklin
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. C. Alsop

(ADDRESS) New Franklin

Filed April 10 1912

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 10, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 9, 1912, to April 10, 1912, that I last saw him alive on April 10, 1912, and that death occurred, on the date stated above, at 6³⁰ P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) ___ yrs. ___ mos. 2 ds.

Contributory (SECONDARY) Paralysis
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. B. Fleet M. D.
April 10, 1912 (Address) New Franklin, 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 New Franklin DATE OF BURIAL 4/11/12 1912

UNDERTAKER W. C. Curtis's New Franklin ADDRESS

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.)



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.

PLACE OF DEATH

County Howard
 Township _____
 or _____
 Village _____
 or _____
 City New Franklin (NO. _____ St. _____ Ward _____)

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

380

Registration District No. _____
 Primary Registration District No. 4224

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

File No. 13309
 Registered No. 9

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

FULL NAME

Charles Carroll Alsop

PERSONAL AND STATISTICAL PARTICULARS

SEX

m

COLOR OR RACE

w

SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

m

DATE OF BIRTH

Set 25

1855

(Month)

(Day)

(Year)

AGE

57

yrs.

mos.

ds.

If LESS than
 1 day, ____ hrs.
 or ____ min.

OCCUPATION

(a) Trade, profession, or particular kind of work

merchandise

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

New Franklin Mo

PARENTS

NAME OF FATHER

Elliot Alsop

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

New Franklin

MAIDEN NAME OF MOTHER

Edna Ann

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

New Franklin

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C C Alsop

(ADDRESS)

New Franklin Mo

FILED

Apr 10 1912

J B Fleet

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Apr 10 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Apr 9 1912, to Apr 10 1912,
 that I last saw him alive on Apr 10 1912,
 and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy Central embolism

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

Paralysis (bulbar)

(Duration) yrs. mos. ds.

(Signed)

J B Fleet M. D.
Apr 10 1912 Address New Franklin Mo

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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

Mt Pleasant

DATE OF BURIAL

Apr 12 1912

UNDERTAKER

N N Curtis

ADDRESS

New Franklin

Original file, date APR 10 1912 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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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.)