

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		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County <u>Wright</u>	Township <u>Gosconade</u>	Registration District No. <u>909</u>	File No. <u>7957</u>
Village _____	City _____ (NO. _____ St. _____ Ward _____)	Primary Registration District No. <u>6221</u>	Registered No. <u>13</u>
FULL NAME <u>John Alford</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number)	
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	DATE OF DEATH <u>Jan 15th</u> , 191 <u>3</u>	
SINGLE <u>Single</u> MARRIED WIDOWED OR DIVORCED (Write the word)		(Month) (Day) (Year)	
DATE OF BIRTH <u>Jan 15</u> , 18 <u>99</u>		I HEREBY CERTIFY, that I attended deceased from <u>Jan 1</u> , 191 <u>2</u> , to <u>Jan 15</u> , 191 <u>3</u> , that I last saw him alive on <u>Jan 15</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>6</u> Pm.	
AGE <u>20</u> yrs. _____ mos. _____ ds.		The CAUSE OF DEATH* was as follows: <u>2317 Tuberculosis</u> <u>Without medical aid</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>I = O</u>		(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>John Alford</u>	8 (Signed) _____ M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	_____, 191____ (Address) _____	
	MAIDEN NAME OF MOTHER <u>Maria Yates</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Barney Yates</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
(ADDRESS) <u>Duncan, Mo</u>		PLACE OF BURIAL OR REMOVAL <u>Int. Burial</u>	DATE OF BURIAL <u>Jan 16</u> , 191 <u>3</u>
Filed <u>Jan 10</u> , 191 <u>3</u>	<u>J. C. Skennett</u> REGISTRAR	UNDERTAKER <u>G. W. Nichols</u>	ADDRESS <u>New Grove</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 BIRTH

County Wright
Township Gasconade
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RE-
CEIVE 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. 907 File No. _____
Primary Registration District No. 6221 Registered No. 13

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

FULL NAME

John Alford

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan 15, 1893
(Month) (Day) (Year)

AGE 20 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) _____

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

PARENTS
NAME OF FATHER Liker Alford
BIRTHPLACE OF FATHER Mo
MAIDEN NAME OF MOTHER Margie Yates
BIRTHPLACE OF MOTHER Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Barney Yates
(ADDRESS) Quincy Mo

Filed Feb 10, 1913, J. A. Fuson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 15, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Jan 1, 1912, to Jan 15, 1913,
that I last saw him alive on _____, 1913,
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis
with out medical aid
(Duration) 4 yrs. _____ mos. _____ ds.

Contributory
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. A. Fuson M. D.
2/10, 1913 (Address) Manassas

*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 _____ yrs. _____ mos. _____ ds.
Where was disease contracted
If not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL mt. Zion DATE OF BURIAL Jan 16, 1913
UNDERTAKER G. W. Nichols ADDRESS New Grove

Revised United States Standard Certificate of Death

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

LCB

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