

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

PLACE OF DEATH

County Monroe

Township ingle

Registration District No. 823

File No. 15482

Village _____

Primary Registration District No. 6138

Registered No. 8

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Emma Julian

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married
(If wife the word)

DATE OF BIRTH June 29, 1863
(Month) (Day) (Year)

AGE 49 yrs. 2 mos. 18 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Kulta Sweden

NAME OF FATHER Erick Erickson

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

MAIDEN NAME OF MOTHER Kara Erickson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. R. Julian

(ADDRESS) Ed. Parad. S. S. 20

Filed April 15, 1913 W. A. Moore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from April 5, 1913, to April 15, 1913, that I last saw her alive on April 14, 1913, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:
Apoplexy
92 F.
(Duration) ____ yrs. ____ mos. 10 ds.

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

(Signed) W. A. Moore M. D. April 15, 1913 (Address) Montenallino

*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 Lincoln Neb. DATE OF BURIAL Apr 17, 1913

UNDERTAKER W. A. Moore ADDRESS

THIS IS A PERMANENT RECORD

N. B.—Every item on this form should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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 BIDDING

WHITE PLAINLY, WITH UNFADING INK—THE OCCUPATION OF DECEASED SHOULD BE STATED IN FULL, WITH ADDRESS, IF KNOWN, AND SHOULD BE VERY IMPORTANT.

PLACE OF DEATH
County Vernon
Township Virgie
Village
City (NO. _____) St. _____ Ward _____

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

Registration District No. 873 File No. _____
Primary Registration District No. 645-8 Registered No. 8

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

FULL NAME Emma Julian

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

DATE OF BIRTH Dec. 29, 1863
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 5, 1913, to Apr. 15, 1913,
that I last saw her alive on Nov. 14, 1913,
and that death occurred, on the date stated above, at 7:30 a.m.

AGE 42 yrs. 2 mos. 16 ds.
If LESS than 1 day, hrs. or min.

The CAUSE OF DEATH* was as follows:

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

Apoplexy
Duration) _____ yrs. _____ mos. 10 ds.
Contributory and information supplied
(Secondary) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
191____ (Address)

BIRTHPLACE (City or town, State or foreign country) Delta, Sweden

NAME OF FATHER Erick Erickson

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

MAIDEN NAME OF MOTHER Rosa Erickson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

(Informant) Satisfactory Information Supplied,

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence Satisfactory Information Supplied.

(ADDRESS)

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL _____ 191____

Filed Apr 16, 1913 M. A. Moore
REGISTRAR

UNDERTAKER Satisfactory Information Supplied ADDRESS _____

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.)

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