

PLACE OF DEATH

County Miller
 Township Salina
 or
 Village
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 561 File No. 17727
 Primary Registration District No. 5752 Registered No. 10

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

FULL NAME David Albertson

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
 DATE OF BIRTH Dec. 13, 1849
 (Month) (Day) (Year)

AGE 63 yrs. 4 mos. 21 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) 1-02

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

PARENTS
 NAME OF FATHER David Albertson
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky
 MAIDEN NAME OF MOTHER Elizabett Albertson
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ira J. Albertson
 (ADDRESS) Empire Mo.

Filed 5/6 1913 J. Temple REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 4, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 19, 1913, to May 4, 1913, that I last saw him alive on May 3, 1913, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:
100 Lobar Pneumonia
1255

(Duration) ____ yrs. ____ mos. 15 ds.

Contributory Acute Septicemia
 (SECONDARY)

(Duration) ____ yrs. ____ mos. 10 ds.

(Signed) J. L. Ghorm M. D.
May 4, 1913 (Address) Empire 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 Lagaville Cemetery DATE OF BURIAL May 4, 1913
 UNDERTAKER Elmer Barker ADDRESS Empire 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*, *Sarcoma*, 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.)

N. B.—Every item of information should be carefully submitted. 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 Miller
Township Daline
Village _____
City _____

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

Registration District No. 561 File No. _____
Primary Registration District No. 5755a Registered No. _____
City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME

David Albertson

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE <u>Married</u>	MARRIED <u>Widowed</u>	DIVORCED <u>None</u>	Supplied.
DATE OF BIRTH <u>May 1, 1913</u> (Month) (Day) (Year)					
AGE <u>24</u> yrs. <u>0</u> mos. <u>0</u> ds. IF LESS than day, hrs. or min.					
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____					
BIRTHPLACE (City or town, State or foreign country) _____					
PARENTS	NAME OF FATHER _____				
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____				
	MAIDEN NAME OF MOTHER <u>Eugene Albertson</u>				
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>				

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH <u>May 4, 1913</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from _____ to _____, 191____.	
that I last saw him alive on _____, 191____.	
and that death occurred, on the date stated above, at _____ m.	
The CAUSE OF DEATH* was as follows: <u>all information was supplied</u>	
Contributory (SECONDARY) _____	
(Signed) _____ 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) Eugene Albertson
(ADDRESS) Eugene, Mo
Filed 5/6 1913 REGISTRAR 5/7/13

PLACE OF BURIAL OR REMOVAL <u>Satisfactory information supplied.</u>	DATE OF BURIAL _____ 191____
UNDERTAKER _____	ADDRESS _____

Revised United States Standard Certificate of Death

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

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