

PLACE OF DEATH

County GreeneMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Township _____

Registration District No. 318File No. 26123

Village _____

Primary Registration District No. 2001Registered No. 447City Springfield NO. 842 Robison St. 5th Ward

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

FULL NAME Christina Olson

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Order
(Write the word)DATE OF DEATH August 22^d, 1913
(Month) (Day) (Year)DATE OF BIRTH Jan 8, 1832
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan 1, 1913, to August 27, 1913, that I last saw her alive on August 27, 1913, and that death occurred, on the date stated above, at 4.4 m.AGE 81 yrs. 8 mos. 20 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 Home Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) A-OMultiple SarcomaBIRTHPLACE (City or town, State or foreign country) Sweden(Duration) ___ yrs. 2 mos. ds.NAME OF FATHER John SwansonContributory Senility
(SECONDARY)BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweden

(Duration) ___ yrs. ___ mos. ds.

MAIDEN NAME OF MOTHER Unknown(Signed) W. H. Brantley M. D.
August 28 1913 (Address) Springfield Mo

BIRTHPLACE OF MOTHER _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) John Olson

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

(ADDRESS) Springfield, Mo

Where was disease contracted if not at place of death?

Filed Aug 28 1913 D. C. W. Smith

Former or usual residence _____

REGISTRAR 11-9 MajorPLACE OF BURIAL OR REMOVAL Haywood DATE OF BURIAL Aug 22 1913UNDERTAKER 11-9 Major ADDRESS City

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

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, peritonaeum*, 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.)

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 Greene
Township _____
or
Village _____
or
City Springfield (NO. 842 Potinorn St.; _____ Ward)

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

Registration District No. 318 File No. _____
Primary Registration District No. 2001 Registered No. 447

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

FULL NAME Christin Olson?

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OF RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widow</u> (Write the word)
DATE OF BIRTH (Month) _____ (Day) <u>1</u> (Year) _____ <i>Satisfactory Information Supplied.</i>		
AGE _____ yrs. _____ mos.		IF LESS than 1 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) <i>Satisfactory Information Supplied.</i>		
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	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 25, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h Satisfactory Information Supplied. alive on _____, 191____,
and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:
multiple sarcoma
of Breast, Female,
with adenoma, glands,
etc. etc.

(Duration) _____ yrs. 2 mos. _____ ds.

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

(Signed) X Dr. Wm. Reeshol M. D.
Aug 28, 1913 (Address) Springfield

*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 Satisfactory Information Supplied. DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Satisfactory Information Supplied.
(ADDRESS) _____
Filed Aug 28, 1913 318 Potinorn
REGISTRAR

Revised United States Standard Certificate of Death

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

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