

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

PLACE OF DEATH  
County Sullivan  
Township Polk  
or  
Village  
or  
City Milam Mo. (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 852 File No. 3617  
Primary Registration District No. 6120 Registered No. 1

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

FULL NAME Albert Richardson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 8, 1858  
(Month) (Day) (Year)

AGE 55 yrs. 10 mos. 8 ds. if LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

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

PARENTS  
NAME OF FATHER John Richardson  
BIRTHPLACE OF FATHER Palmyra Mo  
(City or town, State or foreign country)  
MAIDEN NAME OF MOTHER Elizabeth Smith  
BIRTHPLACE OF MOTHER Not known  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Ex Richardson  
(ADDRESS) Milam Mo

Filed Jan 17, 1914 J. D. Turnell  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 16, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw him alive on about 3 months ago, 1913,  
and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:  
I have never treated Mr. Rich & do not  
to say, only prescribed medicine for his son.  
a Wash. Exam. I saw had decided bone & also  
I think (Duration) 2 yrs. 1 mos. ✓ ds.  
1.55 ft.  
Contributory Don't know  
Neural jaw bone. ulcers & rheumatism & tissue  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Let Mackey M. D.  
Jan. 17<sup>th</sup>, 1914 (Address) Milam 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 home Milam Mo. In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted at milam mo.  
if not at place of death?  
Former or usual residence Milam Mo.

PLACE OF BURIAL OR REMOVAL Casewood Cem Milam Mo DATE OF BURIAL Jan 17, 1914  
UNDERTAKER C. Schoerer Milam Mo ADDRESS

N. B.—Every informant should be personally 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.

Schoerer Milam 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, 8 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 "Asthénia," "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 septicæmia," "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.)

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

PLACE OF DEATH

County Sullivan  
Township Polk  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. 852 File No. \_\_\_\_\_  
Primary Registration District No. 6120 Registered No. \_\_\_\_\_  
(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Albert Richardson

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)

DATE OF BIRTH Sept 1 (Month) (Day) (Year)

AGE 34 yrs. 0 mos. 0 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 \_\_\_\_\_ BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Satisfactory Information Supplied. (ADDRESS) \_\_\_\_\_

Filed Jan 17 1914 J. P. Jewell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 16 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended, deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

I have never treated Mr Richardson to say only prescribed antiseptic solution which can I washed disease bones absent. I think deceased said deceased from pulling of teeth 2 yrs ago. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Neonise jaw Bone abscess (SECONDARY) (Duration) \_\_\_\_\_ mos. \_\_\_\_\_ ds. I can't say that it was tuberculosis, no post-mortem examination. (Signed) E. A. Mackey M. D. 1-17-14 (Address) Milau 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_ ADDRESS \_\_\_\_\_ UNDERTAKER K. C. Schworer Satisfactory Information Supplied.

SUPPLEMENTARY INFORMATION Supplied.

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