

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.

WHILE I LIVE, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Linn
Township Winn
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 569 File No. 3627
Primary Registration District No. 6126 Registered No. 2

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

FULL NAME Alexander Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Mar 21 1889</u> <small>(Month) (Day) (Year)</small>		
AGE <u>74</u> yrs. <u>10</u> mos. <u>2</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
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)		
BIRTHPLACE (City or town, State or foreign country) <u>Ohio</u>		
PARENTS	NAME OF FATHER <u>Olav Anderson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Can't say</u>	
	MAIDEN NAME OF MOTHER <u>Can't say</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>can't say</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 23 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 13 1914, to Jan 23 1914, that I last saw him alive on Jan 23 1914, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis with Abscess of Lung
1010 B
114 B (Duration) 9 yrs. _____ mos. _____ ds.

Contributory Heart some time ago
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. D. Baker M. D.
Jan 24 1914 (Address) Winnigan 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 20 yrs. _____ mos. _____ ds. In the State 47 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) Dell Anderson
(ADDRESS) Alammond Mo

PLACE OF BURIAL OR REMOVAL
Fair View
DATE OF BURIAL
Jan 25 1914
UNDERTAKER
William Coran
ADDRESS
Winnigan Mo

Filed Jan 24 1914 E. D. Baker M.D.
REGISTRAR

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 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 Sullivan
 County Sullivan Registration District No. 859 File No. 1
 Township Morris or _____ or _____ Primary Registration District No. 6125 Registered No. _____
 Village _____ or _____ City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Alexander Anderson

PERSONAL AND STATISTICAL PARTICULARS :

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
 (Write the word)
 DATE OF BIRTH Mar 21 1839
 (Month) (Day) (Year)
 AGE 74 yrs. 10 mos. 2 ds. If LESS than day hrs or min. Suppl. Information
 OCCUPATION (a) Trade, profession, or particular kind of work Farming
 (b) General nature of industry, business, or establishment in which employed (or employer) Suppl. Information
 BIRTHPLACE (City or town, State or foreign country) Ohio
 NAME OF FATHER Charles Anderson
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
 MAIDEN NAME OF MOTHER Scant on
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1-23-1914
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____ to _____, 1914,
 that I last saw h _____ alive on _____, 1914,
 and that death occurred, on the date stated above at _____ m.
 The CAUSE OF DEATH* was as follows:
Chronic Bronchitis with Abscess of Lung.
 (Duration) 90 yrs. _____ mos. _____ ds.
 Contributory Heart some three yrs ago
 (Signed) Wm. C. [Signature] M. D.
1-24-1914 (Address) Winey on Rd.

*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 2 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) Charles Anderson
 (ADDRESS) _____
 Filled Jan 24 1914 Wm. C. [Signature] REGISTRAR

PLACE OF BURIAL OR REMOVAL Winey on Rd. DATE OF BURIAL Jan 20 1914
 UNDERTAKER William [Signature] ADDRESS _____

N. B.—Every item could be carefully applied. AGE should be stated EXACTLY. PHYSICIANS, Therapists, and other persons should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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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.)