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
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

File No. ~~0324~~ 7269

**PLACE OF DEATH**

County: Adair

Township: Salt River

or Village:

or City: (NO. , St.: Ward)

Registration District No. 1

Primary Registration District No. 504

Registered No.

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

**FULL NAME** Francis W. Christensen

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | white | Single |

DATE OF BIRTH: March (Month) 25 (Day), 1914 (Year)

AGE: yrs. mos. 5 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): same

BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS
NAME OF FATHER: Jonas C. Christensen
BIRTHPLACE OF FATHER (City or town, State or foreign country): Iowa
MAIDEN NAME OF MOTHER: Macie Kellar
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W M Christensen
(ADDRESS) Brashear Mo

Filed March 31, 1914. F M Barnes REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: March (Month) 30 (Day), 1914 (Year)

I HEREBY CERTIFY, that ~~I attended deceased from~~ Death without medical, 191, that I last saw Attendance, 191, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:
Obstruction of the Bowels
1570
86 (Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) Convulsions (Duration) yrs. mos. 2 ds.

(Signed) F M Barnes M. D.
March 31, 1914 (Address) Brashear 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 |
|---|---|
| Sabbath home | March 31, 1914 |
| **UNDERTAKER** | **ADDRESS** |
| F R Easley | Brashear |

Returned by authority of Dec 8 Amt bill 149

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association)

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**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 *septichaemia*," "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.)

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

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

**PLACE OF DEATH**

County Adair

Township Salt River

or

Village

or

City (NO. St. Ward)

Registration District No. 1 File No. 1

Primary Registration District No. 5001 Registered No.

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

FULL NAME Francis W. Christensen

**PERSONAL AND STATISTICAL PARTICULARS**

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

DATE OF BIRTH Satisfactory Information Supplied (Month) (Day) (Year)

AGE yrs. mos. ds. 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)

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 Apr 29, 1914. F M Barnes REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Mch 30, 1914 (Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:

Obstruction of the Bowels due to Congenital Stenosis

(Duration) yrs. mos. ds.

Contributory (Secondary) Convulsions

(Duration) yrs. mos. ds.

(Signed) F M Barnes L R M. D.

3-31, 1914 (Address) Brashears

*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

Original file, date MAR 1914, 19 All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

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

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