

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

PLACE OF DEATH  
County Pulaski  
Township Piney  
or  
Village Big Piney  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 114 File No. 13534  
Primary Registration District No. 6943 Registered No. \_\_\_\_\_

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

FULL NAME Alexander Hendrix

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OF RACE white SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)  
DATE OF BIRTH March 27, 1831  
(Month) (Day) (Year)  
AGE 83 yrs. 1 mos. 2 ds. If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work Minister of Gospel  
(b) General nature of industry, business, or establishment in which employed (or employer) Wormia

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 29, 1914  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from April 28, 1914, to April 29, 1914, that I last saw him alive on April 28, 1914, and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH\* was as follows:  
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BIRTHPLACE (City or town, State or foreign country) W. Va.  
PARENTS  
NAME OF FATHER Jessie Hendrix  
BIRTHPLACE OF FATHER (City or town, State or foreign country) W. Va.  
MAIDEN NAME OF MOTHER Abigail Huntington  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) W. Va.

(Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Prostatic hypertrophy  
(SECONDARY) (Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) C. W. Mallett M. D.  
4-29-1914 (Address) Bloodland, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. B. Hendrix  
(ADDRESS) Big Piney, Mo.  
Filed 4/29, 1914 C. W. Mallett  
REGISTRAR

\*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 Big Piney, Mo. DATE OF BURIAL April 30, 1914  
UNDERTAKER C. W. McLaughlin ADDRESS Bloodland, Mo.

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.

ORIGINAL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

# 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 *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 Luzack  
Township Piney  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. 714 File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Alexander Hendrix

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Apr. 29 1914  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_  
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_ 191\_\_\_\_ to \_\_\_\_\_ 191\_\_\_\_  
that I last saw h \_\_\_\_\_ 191\_\_\_\_

AGE \_\_\_\_\_  
IF LESS than \_\_\_\_\_  
yrs. mos. ds. \_\_\_\_\_

and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows:

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

Ascaris  
Chronic Hepatitis  
Prostatic hypertrophy  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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) \_\_\_\_\_

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) C. Wallate M.D.  
729 1914 (Address) Blondell Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_

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

(ADDRESS) \_\_\_\_\_

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Filed June 12 1914 C. Wallate REGISTRAR

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 \_\_\_\_\_  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY INFORMATION Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

N. AND O. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. m. of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state.

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