

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

41083

PLACE OF DEATH
County Scotts
Township Sandhill
or
Village Rutledge Mo
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 811 File No. _____
Primary Registration District No. 6059 4489 Registered No. _____

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

FULL NAME: William Sanders

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR/OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>Nov 11 - 1828</u> (Month) (Day) (Year)		
AGE <u>86</u> yrs. <u>1</u> mos. <u>11</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>same 13</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Kentucky</u>		
PARENTS	NAME OF FATHER <u>Thomas Sanders</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Nancy Douglass</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary Sanders</u> (ADDRESS) <u>Rutledge Mo</u>		
Filed <u>Dec 21 1914</u>	<u>J. R. P. Skitt</u> REGISTRAR	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 21st 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 20th 1914, to Dec 21st 1914, that I last saw him alive on Dec 21st 1914, and that death occurred, on the date stated above, at 10³⁰ pm.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(Duration) ___ yrs. ___ mos. 1 day

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

(Signed) W. S. Petty M. D.
Dec 22 1914 (Address) Rutledge 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 Millport DATE OF BURIAL Dec 23 1914

UNDERTAKER J. R. Bonley ADDRESS Rutledge 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.

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 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.)

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

PLACE OF DEATH

County Scotland

Township _____

Village _____

City Rutledge (NO. _____)

Registration District No. 811

File No. _____

Primary Registration District No. 4484

Registered No. _____

St.: _____ Ward _____

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

FULL NAME

William Sanders

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (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 _____ MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____

Filed 11/21 1911 J. R. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 21, 1911 (Month) _____ (Day) _____ (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1911, that I last saw h _____ alive on _____, 1911, and that death occurred, on the date stated above, at _____ P. M.

CAUSE OF DEATH* was as follows: Orbital Neurotoxic

Contributory _____ (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) W. J. Petty M. D. 1911 (Address) _____

*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 _____ 1911 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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