

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**

PLACE OF DEATH

County Stoddard
Township Easton
or
Village Jeta, Mo
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 837 File No. 7080
Primary Registration District No. 6099 Registered No. 11

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

FULL NAME L. C. Albert

PERSONAL AND STATISTICAL PARTICULARS

2. MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Caucasian SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) _____

DATE OF DEATH Feb. 2, 1915
(Month) (Day) (Year)

DATE OF BIRTH Oct 18 70
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January 25, 1915, to Feb 2, 1915, that I last saw him alive on Jan 1, 1915, and that death occurred, on the date stated above, at 6 A m.

AGE 45 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Edema Lungs
131
1118
(Duration) _____ yrs. _____ mos. 6 ds.

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

Contributory Bright Disease
(SECONDARY) (Duration) 10 yrs. _____ mos. _____ ds.
(Signed) E. A. Binner M. D.
Feb 2, 1915 (Address) Bloomfield Mo

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

PARENTS
NAME OF FATHER Don't Know
BIRTHPLACE OF FATHER Don't Know
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Don't Know
BIRTHPLACE OF MOTHER Don't Know
(City or town, State or foreign country)

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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 _____

(Informant) Bill Fox
(ADDRESS) Jeta Mo

PLACE OF BURIAL OR REMOVAL Gravel Hill DATE OF BURIAL Feb. 3, 1915

Filed 2-2 :9115 J. H. Wilson Mo
REGISTRAR

UNDERTAKER Bessett Bros ADDRESS Bloomfield

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*, *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.)

PLACE OF DEATH

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

County

Township

or Village

or City

Registration District No.

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb. 2, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)

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 above, at _____, m.

AGE _____
If LESS than 1 day, _____ hrs. or _____ min. _____ yrs. _____ mos. _____ ds.

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) _____

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) _____ M. D. _____ 191____ (Address) _____

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

Filed 3-30 1915 John Wilson REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____ UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY Satisfactory information supplied.

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