

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

9195

PLACE OF DEATH
County Lincoln
Township Clark
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 491 File No. _____
Primary Registration District No. 5686 Registered No. 16

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

FULL NAME William Anderson Jr.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Black SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH March 30, 1915
(Month) (Day) (Year)

DATE OF BIRTH March 1, 1890
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 16, 1915, to March 30, 1915, that I last saw him alive on March 30, 1915, and that death occurred, on the date stated above, at 89, m.

AGE 25 yrs. 20 mos. 20 ds. if LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

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

Acute Pneumonic Pulmonary Tuberculosis

BIRTHPLACE (City or town, State or foreign country) Old Monroe

(Duration) ___ yrs. 2 mos. 15 ds.

NAME OF FATHER William Anderson Jr.

Contributory Pneumonia
(Signed) St. A. Stephens M. D.
(Address) Moscow Mills Mo.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Moscow Mills

MAIDEN NAME OF MOTHER Dulcinea Jones

BIRTHPLACE OF MOTHER (City or town, State or foreign country) St Charles

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Maser
(ADDRESS) Moscow Mills Mo

PLACE OF BURIAL OR REMOVAL Moscow Mills Mo DATE OF BURIAL April 1915

Filed March 31, 1915 SD Bruey REGISTRAR

UNDERTAKER None ADDRESS _____

CAUSE OF DEATH: AGE should be stated EXACTLY. PHYSICIAN's statement of OCCUPATION is very important. 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 CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County Linn
Township Clark
or
Village
or
City

Registration District No. 491 File No.
Primary Registration District No. 5656 Registered No. 16
St.: Ward)

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

FULL NAME

William Anderson Jr.

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>B</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> (Write the word)
DATE OF BIRTH (Month) (Day) (Year) <u>1</u> 191 <u>1</u>		AGE yrs. mos.
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employee)		IF LESS than 1 day, hrs. or min.
BIRTHPLACE (City or town, State or foreign country)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 / 30, 1911
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
Acute Pneumonia Pulmonary
Tuberculosis
Tobac Pneumonia

Contributory (SECONDARY)
Tobac Pneumonia
(Duration) yrs. mos. 15 ds.

(Signed) H.A. Shepherd
3 / 31, 1911 (Address) Moscow Mill Mo.

Supplementary Information Supplied.
SUPPLEMENTARY
Supplementary Information Supplied.

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) _____

(ADDRESS) _____

Filed May 5 1911 Shepherd
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 RESIDENCE)
At place of death _____ yrs. _____ 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 _____

NS should take information should be careful in plain text, so that it

Revised United States Standard Certificate of Death

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

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