

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

1 PLACE OF DEATH

County *Butler*

Township *St. Francis*

Village

City

Registration District No. *990*

Primary Registration District No. *533*

(NO. St. Ward)

File No. *80 29945*

Registered No.

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

2 FULL NAME

Doda alee May giffson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH *April 22 1914*
(Month) (Day) (Year)

7 AGE *1 yrs. 4 mos. 8 ds.* If LESS than 1 day or min.

8 OCCUPATION (a) Trade, profession, or particular kind of work *0*
(b) General nature of industry business or establishment in which employed (or employer) *0*

9 BIRTHPLACE (City or town, State or foreign country) *Mo*

PARENTS
10 NAME OF FATHER *John giffson*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ill*
12 MAIDEN NAME OF MOTHER *Florence Shaeffer*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ill*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *John giffson*
(Address) *Rossbauer and*

15 Filed *Oct. 11, 1915* *L McPinney*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *9 30 1915*
(Month) (Day) (Year)

17 I 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.

The CAUSE OF DEATH* was as follows:
Died Without Aid
Medical attendance
1193 (Duration) yrs..... mos..... ds.

CONTRIBUTORY (Secondary) *0* (Duration) yrs..... mos..... ds.
(Signed) *No Physician* M. D.
189 (Address) *0*

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL *Ham Semitery* DATE OF BURIAL *Oct. 1, 1915*

20 UNDERTAKER *Wm Mages* ADDRESS *Rossbauer*

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, 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*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ; "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.)

1 PLACE OF DEATH

County Butte
 Township St. Francis
 or
 Village
 or
 City

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

Registration District No. 990 File No. 10
 Primary Registration District No. 5133 Registered No. 10

2 FULL NAME Soda Alice May Gjesom (NO. _____ St. _____ Ward _____)
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

16 DATE OF DEATH 9-30-1915
 (Month) (Day) (Year)

6 DATE OF BIRTH April 22 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 191____, to _____ 191____, that he last saw _____ alive on _____ 191____, and that death occurred, on the date stated above, at _____ m.

7 AGE 1 yrs. 8 mos. 8 ds. If LESS than 1 day _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

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

Supposed to be inflammation of The Bronchi
 (Duration) _____ mos. _____ ds.

9 BIRTHPLACE (City or town, State or foreign country) _____

CONTRIBUTORY (Secondary) _____ (Duration) _____ mos. _____ ds. Signed Flora Gjesom Mother of child (Address) _____ 191____

10 NAME OF FATHER John Peterson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

12 MAIDEN NAME OF MOTHER Rhance Shocker

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Flora Gjesom (Address) Rombauer

18 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 _____

15 Filed Oct 11 1915 52 McKinney Registrar

19 PLACE OF BURIAL OR REMOVAL Hamm Farm DATE OF BURIAL 10-1-1915
 20 UNDERTAKER W. H. Mayer ADDRESS Rombauer

N. B. - In case of infant, a record of cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH EXACTLY.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

Revised United States Standard Certificate of Death

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

29945
54662

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