

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.

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

32955

PLACE OF DEATH
County Butter
Township Poplar Bluff Mos.
or
Village _____
or
City Pop

Registration District No. 89 File No. _____
Primary Registration District No. 5131 Registered No. 185
St. _____ Ward _____

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

FULL NAME Elvira G. Hendrickson

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Apr. 9th</u> , 19 <u>15</u> (Month) (Day) (Year)		
AGE <u>5</u> yrs. <u>6</u> mos. <u>0</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>child.</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>		
PARENTS	NAME OF FATHER <u>Joseph Hendrickson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Wayne Co., Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Leatha</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Jefferson Co., Ill.</u>	

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Oct. 12</u> , 19 <u>15</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Oct 12</u> , 19 <u>15</u> , to _____, 19 <u>1</u> , that I last saw h <u>im</u> alive on _____, 19 <u>1</u> , and that death occurred, on the date stated above, at <u>1:10</u> m.	
The CAUSE OF DEATH* was as follows: <u>longestomachic</u>	
Contributory (SECONDARY) <u>38</u> _____ (Duration) _____ yrs. _____ mos. <u>2</u> ds.	
(Signed) <u>W. F. Taylor</u> M. D. <u>Nov. 1915</u> (Address) <u>Poplar Bluff</u>	
*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) H. M. Laney
(ADDRESS) Butter Mos
Filed Nov. 1st 1915 Dr. A. K. Room
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Leila Graveyard
DATE OF BURIAL
Oct 12, 1915
UNDERTAKER
none
ADDRESS
Poplar Bluff

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*, *Composer*, *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.)

CAUSE OF DEATH - In printing this form, the cause of death should be stated exactly. Physicians should state exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County Butter
 Township P. Bluff
 or
 Village
 or
 City

Registration District No. 89 File No.
 Primary Registration District No. 5131 Registered No. 185
 No. St. Ward

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

2 FULL NAME

E. A. Neudrerson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>N</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH (Month) (Day) 1 (Year)		
7 AGE yrs. mos. ds.		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country)		
PARENTS	10 NAME OF FATHER	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	12 MAIDEN NAME OF MOTHER	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Oct 13 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
Secondary infection 1915 to 1915
 that I last saw him alive on 10/10/15 1915
 and that death occurred, on the date stated above, at 10:00 m.

THE CAUSE OF DEATH* was as follows:
Chill
04 malaria
 (Duration) yrs. mos. ds.

CONTRIBUTORY
 (Secondary) (Duration) yrs. mos. ds.

(Signed) W. F. Taylor M. D.
NW 1915 (Address)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)
 (Address)

15 Filed NW 1 1915 Dr. A. R. Rows
 Registrar

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 191
20 UNDERTAKER	ADDRESS

Original file, date NW - 1915

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

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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), 29ds.; *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.)

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