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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Marshall

Township Union

or Village

or City (NO. St.; Ward)

Registration District No. 5735 File No. 5295

Primary Registration District No. 27 Registered No. 8

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

FULL NAME James Anderson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: Feby (Month) 4 (Day) 1841 (Year)

AGE: 75 yrs. X mos. (ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Miss

PARENTS
NAME OF FATHER: Thos Anderson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky
MAIDEN NAME OF MOTHER: Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed ____, 191__, ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feby (Month) 15 (Day) 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 2, 1916, to Feby 15, 1916, that I last saw him alive on Feb 15, 1916, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) Don't know

(Duration) X yrs. X mos. X ds.

(Signed) W E Cornell M. D.

Feby 20 1916 (Address) Rush Hollow

*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 76 yrs. X mos. X ds. In the State 75 yrs. mos. ds.

Where was disease contracted if not at place of death? Plum Bush

Former or usual residence Marshall Missouri

PLACE OF BURIAL OR REMOVAL: Wesley Chapel — DATE OF BURIAL: Feby 19 1916

UNDERTAKER: C Grainger — ADDRESS: Lodoma

UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY

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

PLACE OF DEATH

County ____________

Township ____________ Registration District No. ____________ File No. ____________

or

Village ____________ Primary Registration District No. ____________ Registered No. ____________

or

City ____________ (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

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

DATE OF BIRTH

________ (Month) ____ (Day), 1____ (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 (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 ________, 191____, ____________ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ________ (Month) ____ (Day), *191*____ (Year)

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:

____

____________ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____________ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____________ M. D.

________, 191____ (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
	________, 191____
UNDERTAKER	ADDRESS

MANENT RECORD

WRITE PLAINLY, WITH UNFADING INK.—THIS I

N. B.—Every item of information should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may be properly classified.

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

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

1 PLACE OF DEATH

County Lincoln

Township Linn

or

Village

or

City (NO. , St., Ward)

Registration District No. 21

Primary Registration District No. 5735

File No.

Registered No. 3

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

2 FULL NAME James Anderson

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Satisfactory information Supplied. (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) Satisfactory information Supplied.

PARENTS

10 NAME OF FATHER Satisfactory information Supplied.

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)

14 I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Anderson

(Address) Rural Route No

15 Filed Feb 26 1916 W E Cornell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15 1916 (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:

Satisfactory information Supplied.

...(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

...(Duration) ...yrs. ...mos. ...ds.

(Signed) ...M. D.

..., 191... (Address)

*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	DATE OF BURIAL ..., 191...
20 UNDERTAKER	ADDRESS

Original file, date FEB 1916 19...

All information called for must be written on this Supplementary Certificate

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, 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 *septichaemia*," "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.)