

1 PLACE OF DEATH

County WagonTownship
orVillage
orCity nevadaRegistration District No. D75Primary Registration District No. 3039(NO. 312 in chury St.; Ward)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No. 8890Registered No. 42

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

2 FULL NAME Louisa Gabrielsen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE w 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widow6 DATE OF BIRTH aug 20 1938
(Month) (Day) (Year)7 AGE 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.?8 OCCUPATION (a) Trade, profession, or particular kind of work house wife
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE (City or town, State or foreign country) DenmarkPARENTS 10 NAME OF FATHER Mr R. Peterson
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Denmark
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Rolf Gabrielsen
(Address) nevada mo15 Filed 2/1 1916 St. Pitty Registrar Dr Wilson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 31 1916
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from Dec 7 1915 to Jan 31 1916 that I last saw h. a. alive on Jan 24 1916 and that death occurred, on the date stated above, at 9:30 a.m.The CAUSE OF DEATH* was as follows:
1060
bronchitis
(Duration) 1 yrs. 24 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. 24 ds.(Signed) Dr. E. E. Mean M. D.At St. Pitty 1916 (Address) nevada mo

*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 25 yrs. mos. ds. In the 25 yrs. mos. ds. of deathWhere was disease contracted if not at place of death? nevada mo

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Duferwood DATE OF BURIAL 2/2 191620 UNDERTAKER St. J. Hancock ADDRESS nevada mo

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 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 "Asihenia," "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.)

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

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

PLACE OF DEATH
 County Vernon
 Township _____
 or
 Village Nevada
 or
 City _____ (NO. _____) St.: _____ Ward _____

Registration District No. 875 File No. _____

Primary Registration District No. 3039 Registered No. 42

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

2 FULL NAME Louisa Gabrielsen

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Sept 1
(Month) (Day) (Year)

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

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) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (Address) _____

15 Filed 3/26 1916 W. B. Burt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 31 1916
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
90 (Duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) _____
 (Duration) _____ mos. _____ ds.
 (Signed) W. B. Mallow M. D.
277 1916 (Address) Nevada, Mo.

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 _____

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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8890
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.)