

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

PLACE OF DEATH
County Atchison
Township Clarke
or
Village _____
or
City Fairfax Mo (NO. _____ St.: _____ Ward _____)

Registration District No. 17 File No. 31 33404
Primary Registration District No. 4011 Registered No. 149

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

FULL NAME Albertine Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(If wife the word)

DATE OF BIRTH April 3, 1892
(Month) (Day) (Year)

AGE 84 yrs. 6 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH 10 4th 1916
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from Sep 14 - , 1916, to Oct 4 - , 1916, that I last saw her alive on Oct 4th , 1916; and that death occurred, on the date stated above, at 5⁰⁰ m. The CAUSE OF DEATH* was as follows:

BIRTHPLACE (City or town, State or foreign country) Brown Co, Ohio

Paralysis
81A
13^{1/2}
1930 (Duration) _____ yrs. _____ mos. 16 ds.

PARENTS
NAME OF FATHER Milton Drago
BIRTHPLACE OF FATHER (City or town, State or foreign country) Va
MAIDEN NAME OF MOTHER Mary Parker
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va

Contributory Suppression of Urine
(SECONDARY) Uremic Coma (Duration) _____ yrs. _____ mos. 2 ds.
(Signed) A. P. Simpson M. D.
1916 (Address) Fairfax Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. U. Anderson
(ADDRESS) Fairfax Mo

*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 _____

Filed Oct 6 1916. J. W. Blevins
REGISTRAR

PLACE OF BURIAL OR REMOVAL English Grove Cemetery DATE OF BURIAL Oct 6 1916
UNDERTAKER Schooler Bros ADDRESS Fairfax Mo

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.

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, 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), *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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Atchison

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

Township

Registration District No.

File No.

Village

Primary Registration District No.

Registered No.

City

(NO.)

St.

Ward

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

2 FULL NAME

Albertene Anderson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

9 BIRTHPLACE

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Oct 6 1916

J. M. Blevins
Registrar

16 DATE OF DEATH

17

HEREBY CERTIFY, that I attended deceased from

1916 to 1916

that I last saw him alive on 1916

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Paralysis of Acute Meningitis
(Duration) yrs. mos. ds. *16*

CONTRIBUTORS

(Secondary) *Suppression of urine*
(Duration) yrs. mos. ds. *2*

(Signed) *J. M. Blevins* M. D.
10/6 1916 (Address) *Fairfax*

*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

20 UNDERTAKER

ADDRESS

Original file, date *OCT 1916*

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY INFORMATION

Revised United States Standard Certificate of Death

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

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33404
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