

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

1 PLACE OF DEATH

County Peke

Township _____

Village _____

City Louisiana

Registration District No. 689

Primary Registration District No. 3033

(NO. Vanderwerker Hlts. 2 Ward)

File No. 7137

Registered No. 14

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

2 FULL NAME Albert Eldridge Franklin Sanders

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Feb 2 1917
(Month) (Day) (Year)

6 DATE OF BIRTH Feb 4 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Feb 1 1917 to Feb 11 1917 that I last saw him alive on Feb 10 1917 and that death occurred, on the date stated above, at 8a m.

7 AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Malnutrition
15-6
(Duration) _____ yrs. _____ mos. 8 ds.

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

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. H. Hartman M. D.
2/12 1917 (Address) Louisiana Mo

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

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

10 NAME OF FATHER Chas S Sanders

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Linceln Co Mo

Where was disease contracted if not at place of death? _____
Former or usual residence _____

12 MAIDEN NAME OF MOTHER Anna Blevins

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Chas Sanders

PLACE OF BURIAL OR REMOVAL Reveries Mo DATE OF BURIAL 2-13 1917

(Address) Louisiana Mo

15 Filed 2/15 1917 Fred Stettin Registrar

20 UNDERTAKER J. Haley ADDRESS Louisiana Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS 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, 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.)

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 *Pike*
County *Pike* Registration District No. *689* File No. *14*
Township *Lansburg* or Village *Lansburg* Primary Registration District No. *3033* Registered No. *14*
City *Lansburg* (NO. *NO*) St. *NO* Ward *NO*
2 FULL NAME *Albert Eldredge Franklin Sanders* [(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 *A*
MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH *1* (Month) *1* (Day) *1917* (Year)
7 AGE *11* yrs. *11* mos. *11* ds. IF LESS than 1 day.....hrs. or.....min.?

16 DATE OF DEATH *7/14* 191*7*
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from *1917* to *1917*
that I last saw him alive on *7/13* 191*7*
and that death occurred, on the date stated above, at *11:30* a.m.

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)
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)

The CAUSE OF DEATH* was as follows:
Malnutrition
Would not take food - inability to nurse
(Duration) *5* yrs. *5* mos. *5* ds.
CONTRIBUTORY (Secondary) *151*
(Duration) *151* yrs. *151* mos. *151* ds.
(Cause) *W. A. Hardin* M. D.
7/12 191*7* (Address) *Lansburg, Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Fred J. Stults*
(Address) *Lansburg, Mo.*
15 Filed *7/15* 191*7* *Fred J. Stults* Registrar

*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 *Lansburg, Mo.*
19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
20 UNDERTAKER ADDRESS

SUPPLEMENTARY

N. P. A. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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]

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Care should be taken to report specifically the occupations engaged in domestic service for *i. Cook*, *Housemaid*, etc. If the occupation changed or given up on account of the DEATH, state occupation at beginning tired from business, that fact may be *Farmer (retired, 6 yrs.)*. For persons occupation whatever, write *None*.

of cause of death—Name, first, the DEATH (the primary affection with and causation), using always the same for the same disease. Examples: *Ever* (the only definite synonym is cerebrospinal meningitis?); *Diphtheria* (*Croup*?); *Typhoid fever* (never report *monia*?); *Lobar pneumonia*; *Bronchopneumonia*, "unqualified, is indefinite);

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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 "Asthma," "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.)

SEIDLITZ POWDERS.

Dissolve the contents of a box and of a white paper sack
 exactly, each in a tumbler one-third full of water. Mix and
 drink. Formula U. S. D., Ed. 1877, p. 1406.

FRED. D. STICHTER, Graduated Pharmacist,
 Third and Georgia Sts. LOUISIANA, MO.