

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

1 PLACE OF DEATH

County Stoddard
Liberty
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 836 File No. 21008
Primary Registration District No. 6098a Registered No. 39

2 FULL NAME Petersen Adkins

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Feb</u> <u>2</u> <u>1916</u> (Month) (Day) (Year)		
AGE <u>One</u> <u>3</u> <u>mos.</u> <u>21</u> <u>ds.</u>		If LESS than 1 day.....hrs. or.....min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</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>		
10 NAME OF FATHER <u>W. Adkins</u>		
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tenn</u>		
12 MAIDEN NAME OF MOTHER <u>Mary Stevens</u>		
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Adkins
(Address) Defters Mo Post Two

Filed May 21, 1917. J. J. Riddle
Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 27, 1917, to May 21, 1917, that I last saw him alive on May 21, 1917, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Pyelitis
133A
130 (Duration) yrs. One mo. 11 ds.
132B Uraemia
CONTRIBUTORY (Secondary)
(Signed) J. W. Nickerson M. D.
May 21, 1917. (Address) Powell Mo.

*State the Disease Causing Death, or, in death 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 St. Stephens DATE OF BURIAL 5/22 1917

20 UNDERTAKER on L Hadley ADDRESS Bernie mo

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), 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.)

1 PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Stoddard
Wardship Liberty
Village _____
City _____

Registration District No. 836

File No. _____

Primary Registration District No. 6098.0Registered No. 39

(No.)

St.

Ward)

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

2 FULL NAME

Partheimer AdKisue

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>1</u>
6 DATE OF BIRTH _____. 1 _____. 191 _____. (Month) (Day) (Year)		
7 AGE _____. mos. _____. ds.		If LESS than 1 day _____. hrs. or _____. min.?
8 C a) Trade, profession, or particular kind of work b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE a) City or town, b) 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)		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 21, 191 7.
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____.

that I last saw _____ alive on _____, 191 _____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Psychic
Acute Nephritis 119
(Duration) _____. yrs. _____. mos. _____. ds.

CONTRIBUTORY

(Secondary)

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

(Signed) _____ M. D.

May 21, 191 7 (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 _____. 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

_____. 191 _____

Original file, date _____, 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]

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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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