

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

1 PLACE OF DEATH

County Clay
Township Fishing River Registration District No. 198 File No. 40899
or
Village _____ Primary Registration District No. 2011 Registered No. 125-
or
City Oxelawn Springs (No. 624, Highland Park St.) Ward _____

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

2 FULL NAME John Madsen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH Dont know 1. (Month) (Day) (Year)

7 AGE About 34 yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Denmark

PARENTS
10 NAME OF FATHER Soren Madsen
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Denmark
12 MAIDEN NAME OF MOTHER Dont know
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Denmark

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chris Mattson
(Address) Harlan Iowa

15 Filed Dec 3 1917 T. N. Bogart Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 2 1917
(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:
Suicide
Body found Dec 2, 1917
163 Burton Mattby Coroner
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) 163
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Burton Mattby M. D.
Dec 2 1917 (Address) Liberty 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 Carroll Neb.

19 PLACE OF BURIAL OR REMOVAL Crown Hill Cemetery DATE OF BURIAL Dec 3 1917

20 UNDERTAKER E. E. Bulow ADDRESS Oxelawn Springs 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, 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

County *Clay*
 Township _____
 or
 Village _____
 or
 City *S. Springs*

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

Registration District No. _____ File No. *40899*

Primary Registration District No. _____ Registered No. _____

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

2 FULL NAME

John W. Madson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH _____ 191____
 (Month) (Day) (Year) *2 7*

6 DATE OF BIRTH _____
 (Month) (Day) (Year)

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

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

that I last saw him _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

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

Suicide
Body was found dead, death caused by hanging, no cause found

9 BIRTHPLACE (City or town, State or foreign country) _____

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

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) _____

(Signed) *Clinton Maltby Cooper* M. D. *Dec 2*, 1918 (Address) *Liberty Mo.*

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

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

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 _____

15 Filed *Dec 3* 1918 *V. N. Bogart* Registrar

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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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 inter-current) 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.)

Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. STATEMENT OF OCCUPATION. MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Clay
Township _____
or
Village _____
or
City Co. spgs (NO. _____) St. _____ Ward _____

Registration District No. 198 File No. 40899
Primary Registration District No. 3011 Registered No. 125

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

FULL NAME John Madsen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) 1

DATE OF DEATH Dec 2 1917
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1917 to _____, 1917, that I last saw him alive on _____, 1917, and that death occurred, on the date stated above, at _____ m.

AGE About 54 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH was as follows:
Suicide; found Dec 2, after had been dead several days. Poison not known.

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) Denmark

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) Denmark

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Denmark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chris Madsen

(ADDRESS) Harlan Iowa

Filed Dec 3 1917 J. N. Bogart REGISTRAR

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

(Signed) Prueby Mattby Coroner M. D. Dec 2 1917 (Address) Liberty

*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. 2 mos. _____ ds. In the State _____ yrs. 16 mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence Garret Neb

PLACE OF BURIAL OR REMOVAL Crown Hill Cem DATE OF BURIAL Dec 3 1917

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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