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

PLACE OF DEATH

County Sudrain

Township ~~Prairie~~ or Village Laddonia or City ____ (No. ____ St.; ____ Ward)

Registration District No. 24 File No. 7723

Primary Registration District No. 4018 Registered No. ____

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

FULL NAME John Akridge

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write which)
male	White	married

DATE OF BIRTH Aug. (Month) 9 (Day) 1842 (Year)

AGE 75 yrs. 7 mos. 0 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Ky

PARENTS

NAME OF FATHER Ebett Akridge

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

MAIDEN NAME OF MOTHER Susie Bradshaw

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Akridge

(ADDRESS) Laddonia, Mo.

Filed March 11, 1918. W K McCall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mch 9th (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 2, 1918, to Mch. 9, 1918, that I last saw him alive on Mch. 9, 1918, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ____ yrs. 1 mos. 8 ds.

Contributory (Secondary) Paralysis

(Duration) ____ yrs. ____ mos. 8 ds.

(Signed) J M Monroe M. D.

Mch 11 1918 (Address) Laddonia

*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 20 yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? Laddonia Mo.

Former or usual residence Laddonia, Mo.

PLACE OF BURIAL OR REMOVAL Laddonia Mo

DATE OF BURIAL Mch 11 1918

UNDERTAKER W G Granger

ADDRESS Laddonia Mo

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

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

(NO.....St.;.....Ward)

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

IF LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE
(City or town, State or foreign country).....

PARENTS

NAME OF FATHER.....

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

MAIDEN NAME OF MOTHER.....

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed....., 191....., REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

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:

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

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

(Signed).....M. D.

....., 191..... (Address).....

*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.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

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

1 PLACE OF DEATH

County Audrain

Township or Village Laddonia or City

Registration District No. 24 File No.

Primary Registration District No. 4018 Registered No.

(NO. St.; Ward)

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

2 FULL NAME John Akridge

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

(Month) (Day) 1 (Year)

7 AGE

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

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 May 16, 1918 W. K. McCall Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 9, 1918
(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:

Hypostatic pneumonia

94

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis due to Brain Hemorrhage

(Duration) yrs. mos. ds.

(Signed) T. M. Monroe M. D.

May 16 1918 (Address) Laddonia

*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 Laddonia Mo DATE OF BURIAL March 11-1918

20 UNDERTAKER H. G. Grainger ADDRESS Laddonia

Original file, date March 10—, 1918

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]

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), *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.)