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

13739

1 PLACE OF DEATH

County Lafayette

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

Registration District No. 410 ✓ File No. .....

Primary Registration District No. 4474 Registered No. 9

(No. ..... St. ..... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME F. D. Alexander

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | Married |

6 DATE OF BIRTH: Dec. (Month) 7 (Day) 1867 (Year)

7 AGE: 50 yrs. 4 mos. 13 ds. If LESS than 1 day ..... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Lexington Ky

PARENTS

10 NAME OF FATHER: Frank Alexander

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

12 MAIDEN NAME OF MOTHER: Alinta McDaniel

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Alexander
(Address) Mayview Mo

15 Filed April 23 1918 Chas W Ott Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 22nd (Day) 1918 (Year)

17. I HEREBY CERTIFY, that I attended deceased from Feby 11th, 1917, to Apr 22nd, 1918, that I last saw h[illegible] alive on April 17th, 1918, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cancroma of Liver

461

40

(Duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) W A Ott M. D.

4-27-, 1918 (Address) Higginsville 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 .....

19 PLACE OF BURIAL OR REMOVAL: City Cemetery — DATE OF BURIAL: 4/24 1918

20 UNDERTAKER: A H Loader — ADDRESS: Higginsville

# Revised United States Standard Certificate of Death

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

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**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 *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.)

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

**1 PLACE OF DEATH**

County Lafayette

Township ..... Registration District No. 460

or

Village ..... Primary Registration District No. 4234 File No. .....

or

City Higginsville (No. ..... St.; ..... Ward) Registered No. 9

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

**2 FULL NAME** Frank Dewitt Alexander

## 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 April 3, 191 Chas Alt Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 22, 191 8
(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:

.....

.....

.....

..... (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.

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 ..... 191.....

20 UNDERTAKER | ADDRESS

Satisfactory Information Supplied.

# Revised United States Standard Certificate of Death

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

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