

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

1 PLACE OF DEATH

County Boone
Township Lead
or
Village
or
City

Registration District No. 71 File No. 31607
Primary Registration District No. 5710A Registered No. 26
(NO. ~~71~~ St. Ward)

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

2 FULL NAME Nathan Clarence Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>negro</u>	5 SINGLE <u>yes</u> MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>unknown</u> 19 <u>16</u> (Month) (Day) (Year)		
7 AGE <u>2</u> yrs. mos. ds.		If LESS than 1 day, hrs. or min.?
8 OCCUPATION <u>0</u> (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) <u>Finleton, Mo</u>		
PARENTS	10 NAME OF FATHER <u>Nathan Anderson</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>unknown</u>	
	12 MAIDEN NAME OF MOTHER <u>Etta Logan</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>unknown</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 23 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct. 16, 1918, to Oct 23, 1918, that I last saw him alive on Oct. 22, 1918, and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows:
Chumonia
11A 137A 10

(Duration) 11 yrs. mos. ds.

CONTRIBUTORY Influenza
(Secondary) (Duration) 1 yrs. mos. ds.

(Signed) J. Hardy M. D.
Oct. 23, 1918 (Address) Ashland 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.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.P. Hall
(Address) Ashland Mo

15 Filed Oct 29 1918 E.L. Nichols
Registrar

19 PLACE OF BURIAL OR REMOVAL Log Providence DATE OF BURIAL Oct 23, 1918
20 UNDERTAKER Basf. Merc Co. ADDRESS Ashland Mo

Fully supplied. AGE shown stated. Not statement of (DCC) 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.)

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

1. PLACE OF DEATH

County Boone
Township Cedar
City (No. _____) _____ St. _____ Ward _____

Registration District No. 71

File No. _____

Primary Registration District No. 5110-a

Registered No. _____

2. FULL NAME

Nathan Clarence Anderson

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) _____

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

14. INFORMANT

(Address) _____

15. FILED

Oct 23, 1918 A. L. Nichols
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 1918

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Secondary Pneumonia
(duration) yrs. mos. ds. 10

CONTRIBUTORY (SECONDARY)

Influenza
(duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) [Signature] M. D.

, 19 [Signature] (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Log Providence Oct 25 1918

20. UNDERTAKER

ADDRESS

Baro J. Mer Co Arkland Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

N. B.—Every item of information should be carefully checked for accuracy. PHYSICIANS should be especially careful. INFORMATION is very valuable. COMPLETE AS PRESENTED AND RETURN TO BUREAU.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

31607

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NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.