

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

17785

1. PLACE OF DEATH

County Phelps Registration District No. 677 File No. 17785
 Township Rea Primary Registration District No. 4403 Registered No. 29
 City Wm. A. Apelson St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____ (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 23, 1891

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>26</u>	<u>6</u>	<u>3</u>	<u>3</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Soldier 3⁶
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Illinois
 (STATE OR COUNTRY)

10. NAME OF FATHER A. S. Apelson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sweden
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rylander

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sweden
 (STATE OR COUNTRY)

14. INFORMANT (Address) G. B. Wood, Rea Mo.

15. FILED May 30, 1919 Jos. F. Ayers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) _____ 19____

17. I HEREBY CERTIFY, That I attended deceased from _____
Corner _____, May 29, 1919
 that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental Drowned 16.9
 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Epilepsy
 _____ (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 THE DIAGNOSIS? _____

(Signed) Thomas Corner, M. D.

Address Rea Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) 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 Maline Ill DATE OF BURIAL 5/30/19

20. UNDERTAKER H. R. Wood ADDRESS Rea Mo.

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*, *Composer*, *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*, *pneumonia* ("Pneumonia," unqualified, *Tuberculosis of lungs*, *meninges*, *peri Carcinoma*, *Sarcoma*, etc., of origin; "Cancer" is less definite; avoid use for malignant neoplasms); *Measles*; *Chronic valvular heart disease*; *Chronic nephritis*, etc. The contributory (softercurrent) affections need not be stated. Example: *Malaria* (disease of 29 ds.; *Bronchopneumonia* (secondary). Never report mere symptoms or terms such as "Asthenia," "Anemia" (meretric), "Atrophy," "Collapse," "Compressions," "Debility," "Congenital," "Dropsy," "Exhaustion," "Heart hemorrhage," "Inanition," "Marasmus," "Shock," "Uremia," "Weakness," definite diseases can be ascertained. Always qualify all diseases resulting from birth or miscarriage, as "PUERPERAL," "PUERPERAL peritonitis," etc. Still, VIOLENT DEATHS state MEANS OF INJURY as ACCIDENTAL, SUICIDAL, OR HOMICIDE, probably such, if impossible to determine. Examples: *Accidental drowning*; *street car—way 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.)

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.

Maline Dec 14 1925

Dear Sir

This Certificate was not
excepted account of initial
- A his name was Mrs
Emel Axelson

Could you please change it
I am sorry to make you the
trouble

Respectful Mrs Axelson
1357 29 ave

Maline MO

RECEIVED

DEC-16-1925

THE STATE BOARD OF HEALTH
OF MISSOURI

RECEIVED
DEC 16 1925
THE STATE BOARD OF HEALTH
OF MISSOURI

17785