

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

11212
File No. _____
Registered No. 35
St. _____ Ward _____

1. PLACE OF DEATH

County Deer
Township _____
City Nevada (Name) _____

Registration District No. 875
Primary Registration District No. 3039

2. FULL NAME Andrew Long

(a) Residence No. 417 No. Elm St. 7 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 4 - 1845
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 74 9 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(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) Ill -

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

14. INFORMANT (Address) Don Long

15. FILED 2-20-1920 Maguel Faye REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 14 1920

17. I HEREBY CERTIFY That I attended deceased from Dec 26 1919 to Jan 31 1920 that I last saw him alive on Jan 31 1920, and that death occurred, on the date stated above, at 12:5 a.m. 1920

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy (Hemiplegia)
Oct 14 1918 followed with
recurrent attacks Jan 26 1920.
(duration) yrs. mos. da. 6

CONTRIBUTORY (SECONDARY) fracture of third femur
right limb (duration) yrs. mos. da. 35

18. WHERE WAS DISEASE CONTRAICTED at residence
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS: _____
(Signed) J. W. Amersman, M. D.
. 19 (Address) Nevada 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 Clicks Cemetery DATE OF BURIAL Feb 2 19 20

20. UNDERTAKER W J Waincote ADDRESS Nevada

PARENTS

Dr. Amersman

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*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

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.

Amerman

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

1. PLACE OF DEATH

County Vernon
Township Nevada
City Nevada (No.)

Registration District No. 875
Primary Registration District No. 3039

File No.
Registered No. 35
St. Ward)

2. FULL NAME

Andrew Long

(a) Residence No. St. Ward

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (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 19. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1 19 20

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1918, to Feb 1 1920 that I last saw alive on Feb 1 1920, and that death occurred on the date stated above, at 120 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stroke
First stroke Oct 15, 1918
Second stroke Jan 26, 1920
fracture upper 3rd finger right by Dec 26, 1919
Cause of death hemiplegia
last stroke (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Accidental fracture of
upper third penul right leg, the got
ant. hilt fell, (duration) yrs. mos. da. 37

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) J. W. Amerman M. D.
19 (Address) Nevada Mo.

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

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21211
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