

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

7880

1. PLACE OF DEATH

County Barnes Registration District No. 36 File No. _____
 Township Sugar Creek Primary Registration District No. 5052 Registered No. _____
 City _____ (No. _____, St. _____, Ward _____)

2. FULL NAME

Rachel Emilee 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 | 2 | 1 | _____

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Gas Louden

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

12. MAIDEN NAME OF MOTHER Giddings

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

14. INFORMANT (Address) _____

15. FILED _____ 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 27 1923

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to Mar 27, 1923 that I last saw h. or alive on Mar 26, 1923, and that death occurred, on the date stated above, at Deligan, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
23A
31 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

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) J. S. Parker, M. D.
 , 19 (Address) Deligan 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 Bales Cemetery DATE OF BURIAL 3/28 1923

20. UNDERTAKER Lonny L. Crockett ADDRESS Deligan 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, 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 *Nons.*

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 neoplasma); *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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County Barry 36 State MISSOURI Registered No. _____
 Township Sugar Creek 5052 or Village _____ or
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rachel Emiline 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 fr **4 COLOR OR RACE** w **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** m
(write the word)

5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Jan 26, 1958

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 _____
 11-3184 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 19 23

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
 that I last saw h----- alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The **CAUSE OF DEATH*** was as follows:

Tuberculosis Lungs

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____
 (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) J. S. Hester, M. D.
 , 19 (Address) See ym w

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19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ **DATE OF BURIAL** _____

_____ 19 _____

20 UNDERTAKER _____ **ADDRESS** _____

SUPPLEMENTAL

INSTRUCTIONS: See instructions on reverse side.

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11-3184

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