

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

18981

1. PLACE OF DEATH
County Morgan Registration District No. 74
Township Nichland Primary Registration District No. 5797C
City Springfield, Mo. St. Mo. Ward) 5706
File No. 1
Registered No. 601

2. FULL NAME Richard Aldrich
(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 Male
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 _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-16-1851
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
75 11 28 = _____
8. OCCUPATION OF DECEASED Farmer 921
(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 _____

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14-1927
17. I HEREBY CERTIFY, That I attended deceased from 5-30-1927 to 6-14-1927, and that I last saw him alive on 6-11-1927, and that death occurred, on the date stated above, at 11:03 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Valvular Heart disease
900 (duration) 2 yrs. 1 mo. 1 ds.
CONTRIBUTORY (SECONDARY) paralysis of right side (duration) _____ yrs. _____ mos. 16 ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? _____
19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) W. H. Fogle, M. D.
6/16/1927 (Address) Atterville Mo

9. BIRTHPLACE (CITY OR TOWN) New York
(STATE OR COUNTRY) _____
10. NAME OF FATHER Herish Aldrich
11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New York
(STATE OR COUNTRY) _____

*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.)

14. INFORMANT Charles Aldrich
(Address) Atterville Mo RFD
15. FILED 6/17/27 Of Co Mo
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield DATE OF BURIAL 6-17-1927
20. UNDERTAKER Jewell E. Richards ADDRESS Linton Mo

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MISSOURI STATE BOARD OF HEALTH

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; Broncho-pneumonia* ("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 neoplasm); *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.; *Broncho-pneumonia* (secondary), 10ds. 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.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION COLLECTED
HEREON MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Morgan Registration District No. 601 File No. 4
Township Richland Primary Registration District No. 3796 Registered No. 5
City (No.) St. Ward

2. FULL NAME Richard Aldrich

(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) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 11 28

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) New York

10. NAME OF FATHER Geriah Aldrich

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

12. MAIDEN NAME OF MOTHER Ann K.

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

14.

INFORMANT C. Charles Aldrich
(Address) Atterville Mo. R.F. 2

15.

FILED 7/7 1927 E. E. Holtzen M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 19 27

17. I HEREBY CERTIFY That I attended deceased from May 30 to June 14, 1927 that I last saw h. alive on June 11, 19. 27 and that death occurred, on the date stated above, at 11:03 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Valvular Heart disease

CONTRIBUTORY (SECONDARY) Paralysis of Right side
(duration) 15 yrs. — mos. — ds.
(duration) — yrs. — mos. 16 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) Robt L. Fogle M. D.
6/16 1927 (Address) Atterville, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Syracuse June 17 19 27
20. UNDERTAKER Jewell C. Richards ADDRESS Dipton Mo.

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

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that carefully equipt. "deaths" may be properly classified. Exact. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that carefully equipt. "deaths" may be properly classified. Exact.

SUPPLEMENTARY

S-18981