

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

18918

1. PLACE OF DEATH

County Nodaway  
Township Greene  
City (No. ....) .....

Registration District No. 628  
Primary Registration District No. 2830

File No. ....  
Registered No. 114  
St. .... Ward)

2. FULL NAME

(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.

Agasta Lundeen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 26, 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
80 5 20

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) Housework  
(c) Name of employer .....

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

10. NAME OF FATHER D.K.

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

12. MAIDEN NAME OF MOTHER D.K.

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

14. INFORMANT Albert Lundeen  
(Address) S Kidmore, Mo.

15. FILED ..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 16 1929

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to May 16, 1929 that I last saw her alive on May 16, 1929, and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Apoplexy  
82 F  
(duration) 1 yrs. 1 mo. 1 ds.  
102  
CONTRIBUTORY (SECONDARY) High blood pressure  
Arteriosclerosis  
(duration) 6 yrs. 1 mo. 1 ds.

18. WHERE WAS DISEASE CONTRACTED  
IS NOT A PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF .....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) Dr. J. L. Manning, M. D.  
, 19 (Address) S Kidmore, 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 DATE OF BURIAL  
Burlington, Ohio, Cemetery  
Burlington Junction, Mo. May 17 1929

20. UNDERTAKER Valley & Sons Maitland, Mo.  
ADDRESS

# 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 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.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Hodaway  
Township Greene  
City..... (No..... St..... Ward)

Registration District No. 628  
Primary Registration District No. 3-830

File No.....  
Registered No. 114

**2. FULL NAME**

Agusta Lamberson  
(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		

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

7. AGE YEARS <u>50</u>	MONTHS <u>5</u>	DAYS <u>20</u>	IF LESS than 1 day, ..... hrs. or ..... min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House 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) Sweden

10. NAME OF FATHER W. J. Lamberson

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) Sweden

4. INFORMANT Robert Lamberson  
(Address) Shelburne Mo

5. FILED May 17, 1929 J. E. Jones REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 16 1929

17. I HEREBY CERTIFY that I attended deceased from May 15 1929 to May 16 1929 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 6 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

High Blood Pressure

CONTRIBUTORY (SECONDARY) arteriosclerosis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Dr. J. C. Manning, M. D.

, 19..... (Address) Shelburne 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 Ohio Cemetery Burlington Mo DATE OF BURIAL May 17 1929

20. UNDERTAKER Kelly & Sons ADDRESS Mantoloud

**SUPPLEMENTARY**

5-18718