

WHILE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH  
County Madison  
Township \_\_\_\_\_ Registration District No. 2 File No. 27249  
or  
Village \_\_\_\_\_ Primary Registration District No. 9001 Registered No. 103  
or  
City Kirksville (NO. 95, East St.; 3 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]  
FULL NAME Robert Gale Alexander

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> (Write the word)	DATE OF DEATH <u>Aug 16</u> , 191 <u>1</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>June 2nd</u> , 1818 (Month) (Day) (Year)		I HEREBY CERTIFY, that I attended deceased from <u>Aug 15</u> , 191 <u>1</u> , to <u>Aug 16</u> , 191 <u>1</u> , that I last saw him alive on <u>Aug 16</u> , 191 <u>1</u> , and that death occurred, on the date stated above, at <u>11</u> P. M.			
AGE <u>93</u> yrs. <u>2</u> mos. <u>14</u> ds.	IF LESS than 1 day, ___ hrs. or ___ min.?		The CAUSE OF DEATH* was as follows: <u>154</u> <u>Contributory Indigestion</u> (Duration) yrs. ___ mos. <u>2</u> ds. (Signed) <u>A. V. Parrish</u> M. D. <u>Aug 17</u> , 191 <u>1</u> (Address) <u>Kirksville Mo</u>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Merchant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>4-33 16th St</u>		*State the Disease-Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.			
BIRTHPLACE (City or town, State or foreign country) <u>New York State</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds. Where was disease contracted if not at place of death? Former or usual residence _____			
PARENTS	NAME OF FATHER <u>Unknown</u>	PLACE OF BURIAL OR REMOVAL <u>Wm Waddill</u>			
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Vermont</u>	DATE OF BURIAL <u>8/18</u> , 191 <u>1</u>			
	MAIDEN NAME OF MOTHER <u>Unknown</u>	UNDERTAKER <u>James City Mo</u>			
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	ADDRESS <u>Kirksville</u>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Inferment) <u>Thomson Alexander</u> (ADDRESS) <u>Kirksville Mo</u>		FILED <u>8/17</u> , 191 <u>1</u> REGISTRAR <u>E. C. Collins</u>			

# 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*, *Sar-*

*coma*, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)



## PLACE OF DEATH

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

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

County Adair Registration District No. 4. File No. \_\_\_\_\_  
 or \_\_\_\_\_  
 Village Wilder Primary Registration District No. 3001 Registered No. 103  
 or \_\_\_\_\_  
 City Wilder No. 13 St. 3 Ward \_\_\_\_\_  
 FULL NAME Albert Leake Alexander

(If death occurred in a hospital or institution, give its NAME instead of street and number)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX <u>Male</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u>	DATE OF DEATH <u>Aug 16, 1911</u> (Month) (Day) (Year)
DATE OF BIRTH <u>June 2, 1818</u> (Month) (Day) (Year)			HEREBY CERTIFY, that I attended deceased from <u>Aug 15, 1911</u> , to <u>Aug 16, 1911</u>
AGE <u>93 yrs. 2 mos. 14 ds.</u>			that I last saw him alive on <u>Aug 16, 1911</u>
OCCUPATION (a) Trade, profession, or particular kind of work <u>Merchant</u>			and that death occurred, on the date stated above, at <u>11 P. M.</u>
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Worcester</u>			The CAUSE OF DEATH* was as follows: <u>Senility</u>
BIRTHPLACE (City or town, State or foreign country) <u>New York State</u>			(Duration) yrs. mos. ds. <u>2 ds.</u>
PARENTS	NAME OF FATHER <u>Unknown</u>		Contributory (SECONDARY) <u>Indigestion</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Vermont</u>		(Duration) yrs. mos. ds. <u>0 yrs. 0 mos. 0 ds.</u>
	MAIDEN NAME OF MOTHER <u>Unknown</u>		(Signed) <u>H. H. Parrish</u> M. D.
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>"</u>		<u>Aug 14, 1911</u> (Address) <u>Kirksville, Mo.</u>
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Thornton Alexander</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
(ADDRESS) <u>Kirkville, Mo.</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
Filed <u>8/17</u> 1911 <u>E. H. Callison</u> REGISTRAR			At place of death yrs. mos. ds. In the State yrs. mos. ds.
Original file, date <u>AUG 17</u> 1911			Where was disease contracted if not at place of death?
			Former or usual residence
			PLACE OF BURIAL OR REMOVAL <u>Green City, Mo.</u>
			DATE OF BURIAL <u>8-18</u> 1911
			UNDERTAKER <u>J. T. Maddill</u>
			ADDRESS <u>Wilder</u>

Original file, date AUG 17 1911

All information called for must be written on this Supplementary Certificate.

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27249