

MARGIN RESERVED FOR BINDING

WRITE 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 Rex  
 County Rex Registration District No. 975 File No. 37199  
 Township Knoxville or X Primary Registration District No. 6236 Registered No. 16  
 Village X or \_\_\_\_\_ City X (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 FULL NAME Ruth Lonnie Albertson [If death occurred in a hospital or institution, give its NAME instead of street and number]

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Female COLOR OR RACE White SINGLE X MARRIED Widow OR DIVORCED Single (Write the word)  
 DATE OF BIRTH Oct 10, 1913  
 (Month) (Day) (Year)  
 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 21 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
 OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_ (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 BIRTHPLACE (City or town, State or foreign country) Mo  
 PARENTS: NAME OF FATHER Wigner Albertson BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo MAIDEN NAME OF MOTHER Mertle Tate BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Nov 1, 1933  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 The CAUSE OF DEATH\* was as follows:  
Dyspepsia and that death was caused by Pneumonia  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.  
 Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) S. D. Smith M. D.  
Nov 1, 1933 (Address) Council Bluffs  
 \*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
 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 \_\_\_\_\_  
 PLACE OF BURIAL OR REMOVAL Naubee County DATE OF BURIAL Nov 1, 1933  
 UNDERTAKER None ADDRESS \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Wigner Albertson  
 (ADDRESS) Council Bluffs Mo  
 Filed Nov 14, 1933 John F. Clarke  
 REGISTRAR

# 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 *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.)



DING INK—THIS IS A PERMANENT REC

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

PLACE OF DEATH

County Ray  
Township Knorrville  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

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

Registration District No. 915 File No. \_\_\_\_\_  
Primary Registration District No. 6236 Registered No. 16

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

FULL NAME Ruth Louise Albertson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than \_\_\_\_\_ day \_\_\_\_\_ hrs \_\_\_\_\_ or \_\_\_\_\_ min.

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

BIRTHPLACE  
(City or town, State or foreign country) \_\_\_\_\_

PARENTS  
NAME OF FATHER \_\_\_\_\_  
BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
MAIDEN NAME OF MOTHER \_\_\_\_\_  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Satisfactory Information Supplied

(ADDRESS) \_\_\_\_\_  
Filed 11/14 1913 by John F. Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 1, 1913  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1913,  
that I last saw him alive on \_\_\_\_\_, 1913,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* was as follows:  
Indigestion Indications  
are that death was caused by  
Pneumonia Bronchial  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
(SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. S. Stewart M. D.  
1913 (Address) Cougill, Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY Satisfactory Information Supplied.

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37199