

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

PLACE OF DEATH
County Carroll
Township Smith
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 136 File No. 1 38599
Primary Registration District No. 6254 Registered No. 19

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

FULL NAME David Bjoekstrom

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH March 4, 1911
(Month) (Day) (Year)
AGE 1 yrs. 5 mos. 24 ds. IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Kansas City, Mo.

PARENTS
NAME OF FATHER G.A. Bjorkstrom
BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweeden
MAIDEN NAME OF MOTHER Lillian May Schreiber
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pettis Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G.A. Bjorkstrom

(ADDRESS) Kansas City Mo.

Filed Dec 4 1912 J.D. Logan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 28, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 27, 1912, to Aug. 28, 1912, that I last saw her alive on Aug. 27, 1912, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:
38
Rachitis
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory malaria Fever
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. B. Austin M. D.
8/28 1912 (Address) Brunswick, 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 Kansas City Mo. DATE OF BURIAL Aug. 28 1912
UNDERTAKER L. W. Heisel ADDRESS Brunswick Mo.

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.

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*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, 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 "*Asihenia*," "*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 septichaemia*," "*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.)

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
County Carrroll
Township Smith
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 169 File No. 38399
Primary Registration District No. 0235 Registered No. 11

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

FULL NAME Lovida Bjorkstrom

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>March 4, 1911</u> (Month) (Day) (Year)		
AGE <u>1 yrs. 5 mos. 24 ds.</u> if LESS than 1 day, _____ hrs. or _____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 28, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 22, 1912, to Aug. 28, 1912, that I last saw her alive on Aug. 27, 1912, and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:
Rachitis 38
6 1/2

BIRTHPLACE
(City or town, State or foreign country) Kansas City Mo.

PARENTS	NAME OF FATHER <u>G.A. Bjorkstrom</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Sweden</u>
	MAIDEN NAME OF MOTHER <u>Lillian May Schreiber</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Pettis Co Mo</u>

(Duration) 1 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) Malaria Fever

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. B. Austin M. D.
8-28-1912 (Address) Brunswick Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G.A. Bjorkstrom
(ADDRESS) Kansas City Mo.

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 _____

Filed Aug 28 1912 M. B. Austin
REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Kansas City Mo.</u>	DATE OF BURIAL <u>Aug 28, 1912</u>
UNDERTAKER <u>L. W. Haisil</u>	ADDRESS <u>Crosswicks Mo.</u>

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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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.)

