

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

PLACE OF DEATH

County Franklin

Township \_\_\_\_\_

or Village \_\_\_\_\_

or City Sullivan

(NO. \_\_\_\_\_)

Registration District No. 295

File No. 27954

Primary Registration District No. 4179

Registered No. 26

St. 2<sup>nd</sup> Ward

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

FULL NAME

Henry Fisher

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widow  
(Write the word)

DATE OF BIRTH June 13, 1828  
(Month) (Day) (Year)

AGE 83 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Shoe Maker (Retired)  
(b) General nature of industry, business, or establishment in which employed (or employer) 5-52

BIRTHPLACE (City or town, State or foreign country) Switzerland

PARENTS  
NAME OF FATHER Mat Kumin  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Switzerland  
MAIDEN NAME OF MOTHER Mat Kumin  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Switzerland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Fisher  
(ADDRESS) Sullivan Mo

Filed Aug 18 1911 O. P. Schudde REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 15, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from no medical, 1911, to attendance, 1911, that I last saw him alive on \_\_\_\_\_, 1911, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Old age  
162  
17  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) O. P. Schudde M. D.  
Aug 18 1911 (Address) Sullivan 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 D. O. F. Cemetery DATE OF BURIAL Aug 17, 1911  
UNDERTAKER J. T. Williams ADDRESS Sullivan Mo

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 \_\_\_\_\_  
 Township \_\_\_\_\_  
 or Village \_\_\_\_\_  
 or City \_\_\_\_\_ (NO. \_\_\_\_\_)  
 Registration District No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_  
 File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_  
 SINGLE MARRIED WIDOWED OR DIVORCED (If not in the word)  
 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 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)  
 BIRTHPLACE OF FATHER \_\_\_\_\_ (City or town, State or foreign country)  
 MAIDEN NAME OF MOTHER \_\_\_\_\_ (City or town, State or foreign country)

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 THE CAUSE OF DEATH was as follows:

**PARENTS**

NAME OF FATHER \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 BIRTHPLACE OF FATHER \_\_\_\_\_ (City or town, State or foreign country)  
 MAIDEN NAME OF MOTHER \_\_\_\_\_ (Address) \_\_\_\_\_ M. D.  
 BIRTHPLACE OF MOTHER \_\_\_\_\_ (City or town, State or foreign country)

\* 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 \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted if not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

**THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

REGISTRAR \_\_\_\_\_

PLACE OF DEATH

County Franklin

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

Township \_\_\_\_\_

Registration District No. 295File No. 1

Village \_\_\_\_\_

Primary Registration District No. 4179Registered No. 26City: Sullivan (NO. \_\_\_\_\_)St.: 2 Ward) \_\_\_\_\_

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

FULL NAME Henry Fisher

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed  
(Write the word)DATE OF BIRTH June 13, 1828  
(Month) (Day) (Year)AGE 93 yrs. 2 mos. 2 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?OCCUPATION (a) Trade, profession, or particular kind of work Shoe maker (retired)

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) SwitzerlandNAME OF FATHER Not knownBIRTHPLACE OF FATHER (City or town, State or foreign country) SwitzerlandMAIDEN NAME OF MOTHER Not knownBIRTHPLACE OF MOTHER (City or town, State or foreign country) Switzerland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Fisher(ADDRESS) Sullivan MoFiled Aug. 18<sup>th</sup> 1911 O. N. Schuda REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 15, 1911  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from professional attendance that I last saw him alive on \_\_\_\_\_, 1911, and that death occurred, on the date stated above, at 1 A.M.The CAUSE OF DEATH\* was as follows: old age

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) O. N. Schuda M. D. Aug 15, 1911 (Address) Sullivan 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 O. O. F. Cemetery DATE OF BURIAL Aug 17, 1911UNDERTAKER J. T. Williams ADDRESS Sullivan MoOriginal file, date AUG 18 1911

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

# 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); *Mcasles*; *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 septichoemia," "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.)

27954