

Exact statement of OCCUPATION in very important.

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

PLACE OF DEATH

County Stoddard
Township Pike
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 835 File No. 342681A

Primary Registration District No. 6097B Registered No. 47

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

FULL NAME Foy Franklin Adams

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH January 15, 1911
(Month) (Day) (Year)

AGE 26 yrs. 9 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1-10

BIRTHPLACE Stoddard County Missouri
(City or town, State or foreign country)

PARENTS
NAME OF FATHER Francis Adams
BIRTHPLACE OF FATHER Bollinger Co Mo
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Missouri Sides
BIRTHPLACE OF MOTHER Stoddard Co Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Q Adams
(ADDRESS) Padock Mo

Filed 10/25 1911 REGISTRAR X

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October 24, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from October 12, 1911, to October 24, 1911, that I last saw him alive on October 22, 1911, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:
Typhoid fever
(Duration) ___ yrs. ___ mos. 15 ds.

Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Dr. W. T. Tumbough M. D.
Oct 24, 1911 (Address) Bloomfield 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 Nations Cemetery DATE OF BURIAL 10-25-1911
UNDERTAKER Dr. Hazler ADDRESS Bloomfield Mo

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.)



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

PLACE OF DEATH
County Stoddard
Township Pike
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 835 File No. _____
Primary Registration District No. 6097B Registered No. 47

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

FULL NAME Foy Franklin Adams.

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
DATE OF BIRTH January 15, 1888
(Month) (Day) (Year)
AGE 26 yrs. 9 mos. 9 ds. IF LESS than 1 day, ___ hrs. or ___ min. ?
OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

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

PARENTS
NAME OF FATHER Francis Adams
BIRTHPLACE OF FATHER (City or town, State or foreign country) Bollinger Co. Mo.
MAIDEN NAME OF MOTHER Missouri Siders
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Stoddard Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John S. Adams
(ADDRESS) Zadock Mo.

Filed 10/25/1911 by C. O. Bennetts
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 24, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 12, 1911, to Oct. 24, 1911, that I last saw him alive on " 22, 1911, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* was as follows:
Dysphoid fever

(Duration) _____ yrs. _____ mos. 15 ds.
Contributory _____
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Thos. B. Turnbaugh M. D.
Oct. 24 1911 (Address) Bloomfield 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 Nations Cemetery DATE OF BURIAL 10-25, 1911

UNDERTAKER H. A. Harper ADDRESS Bloomfield Mo.

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 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.)

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