

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Harrison

Township _____

or _____

Village _____

or _____

City Bethany Mo. (NO. _____)Registration District No. 384File No. 41207 78Primary Registration District No. 4197

Registered No. _____

St. _____ Ward _____

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

FULL NAME Viola F. Frisby

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Divorced
(Write the word)DATE OF DEATH Dec 7, 1911
(Month) (Day) (Year)DATE OF BIRTH Sept 23 1851
(Month) (Day) (Year)I HEREBY CERTIFY that I attended deceased from at time of death, 1911,
that I last saw him alive on _____, 1911,
and that death occurred, on the date stated above, at 6.0 m.AGE 60 2 14 - If LESS than
1 day, _____ hrs.
or _____ min.?
yrs. mos. ds.

THE CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer(b) General nature of industry, business, or establishment in which employed (or employer) ✓BIRTHPLACE (City or town, State or foreign country) Greenville IndianaNAME OF FATHER J. E. BunchBIRTHPLACE OF FATHER (City or town, State or foreign country) Don't knowMAIDEN NAME OF MOTHER Rebecca BirdBIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Minnie A. Elk(ADDRESS) Bethany Mo.Filed Dec 9 1911 J. A. [Signature] REGISTRARCerebral Hemorrhage
Instantaneous
(Duration) _____ yrs. _____ mos. _____ ds.Contributory none known
(SECONDARY) _____ yrs. _____ mos. _____ ds.(Signed) [Signature] M. D.1911 (Address) Bethany

*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 MeramecDATE OF BURIAL _____ 1911UNDER TAKER [Signature]ADDRESS Bethany 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*, *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*, *peritonacum*, 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

County Harrison

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Township Bethany Mo.
or
Village
or
City

Registration District No. 334
Primary Registration District No. 4197

File No. 41207
Registered No. 78

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

FULL NAME Viola F. Frisby

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Divorced</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Sept 23</u> , 18 <u>51</u> <small>(Month) (Day) (Year)</small>		
AGE <u>60</u> yrs. <u>2</u> mos. <u>14</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE Crawfordsville Indiana
(City or town, State or foreign country)

PARENTS	NAME OF FATHER <u>J. E. Birch</u>
	BIRTHPLACE OF FATHER <u>Don't know</u> <small>(City or town, State or foreign country)</small>
	MAIDEN NAME OF MOTHER <u>Rebecca Birch</u>
	BIRTHPLACE OF MOTHER <u>Don't know</u> <small>(City or town, State or foreign country)</small>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Minnie Melk
(ADDRESS) Bethany, Mo.

Filed Dec 9 1921 Jackson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 7, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from at time of death to 1921, that I last saw him alive on, 1921, and that death occurred, on the date stated above, at 60 yrs.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage -
Instantaneous ds.

Contributory (SECONDARY) None known
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) F. H. Broyle M. D.
Dec 9 1921 (Address) Bethany

*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 <u>Meriam</u>	DATE OF BURIAL <u>Dec 8</u> , 19 <u>21</u>
UNDERTAKER <u>E. W. Benter</u>	ADDRESS <u>Bethany 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.)