

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

PLACE OF DEATH

County Callaway

Township _____

or Village _____

City Fulton (NO. _____)

Registration District No. 104

File No. 12654

Primary Registration District No. 3008

Registered No. 45

FULL NAME Fannie Smith

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE negro SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) Single

DATE OF DEATH March 31, 1912
(Month) (Day) (Year)

DATE OF BIRTH Dec. 1826
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 31, 1912, to March 31, 1912

AGE about 86 yrs. mos. ds. If LESS than 1 day, ___ hrs. or ___ min.?

that I last saw her alive on March 31, 1912, and that death occurred, on the date stated above, at ___ m.

OCCUPATION (a) Trade, profession, or particular kind of work General House Work
(b) General nature of industry, business, or establishment in which employed (or employer) g. H.

The CAUSE OF DEATH* was as follows:

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

Cerebral Apoplexy
g. H.
U. Y.
(Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER Don't know

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know

(Signed) J. W. Supton M. D.
1912 (Address) Fulton Mo.

MAIDEN NAME OF MOTHER Don't know

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 1 yrs. ___ mos. ___ ds. In the State 8 yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death?
Former or usual residence Fulton Mo.

(Informant) Maud Noel

PLACE OF BURIAL OR REMOVAL Fulton DATE OF BURIAL April 1, 1912

(ADDRESS) Fulton Mo.

Filed 4/1 1912 H. E. Peely REGISTRAR

UNDERTAKER Mitchell Brooks ADDRESS Fulton

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.

THIS IS A PERMANENT RECORD

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); *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

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

County Calloway

Township

Registration District No. 104File No. 12654or
VillagePrimary Registration District No. 3008Registered No. 45or
City Fulton

(NO. _____)

St.: _____

Ward) _____

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

FULL NAME Fannie Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Female

COLOR OR RACE

Black

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

DATE OF DEATH

March 31, 1912
(Month) (Day) (Year)

DATE OF BIRTH

D.K., 1826
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from March 31, 1912, to March 31, 1912, that I last saw her alive on March 31, 1912, and that death occurred, on the date stated above, at _____ m.

AGE

ab 86
yrs. mos. ds.If LESS than
1 day, _____ hrs.
or _____ min.

The CAUSE OF DEATH* was as follows:

OCCUPATION
(a) Trade, profession, or particular kind of workGeneral HouseworkCerebral apoplexy

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

BIRTHPLACE

(City or town, State or foreign country)

Calloway Mo.

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

PARENTS
NAME OF FATHERDont knownContributory
(SECONDARY)

Duration _____ yrs. _____ mos. _____ ds.

BIRTHPLACE OF FATHER
(City or town, State or foreign country)Dont known(Signed) J. D. Sexton M. D.Bl. (Address) Fulton Mo

MAIDEN NAME OF MOTHER

Dont known

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

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)Dont known

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, _____ yrs. _____ mos. _____ ds. In the 86 yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maud NoelWhere was disease contracted
If not at place of death?Former or usual residence Fulton(ADDRESS) Fulton Mo

PLACE OF BURIAL OR REMOVAL

Fulton

DATE OF BURIAL

Apr 1, 1912

Filed

W. E. Kelly
REGISTRAR

UNDERTAKER

Mitchell Brooks

ADDRESS

Fulton

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

This form is printed in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. EXACTLY PHYSICIANS should state

Revised United States Standard Certificate of Death

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

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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.)