

## PLACE OF DEATH

County BuchananTownship Washington

Village \_\_\_\_\_

City \_\_\_\_\_ (NO. Woodson's Sanitarium Ward)MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHRegistration District No. 86File No. 28838Primary Registration District No. 86527Registered No. 71

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

FULL NAME W. B. Fisk

## PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed  
(If wife the word)DATE OF BIRTH Sept - 11, 1835  
(Month) (Day) (Year)AGE 76 yrs. 11 mos. 20 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) 1-02BIRTHPLACE (City or town, State or foreign country) New YorkNAME OF FATHER James FiskBIRTHPLACE OF FATHER (City or town, State or foreign country) EnglandMAIDEN NAME OF MOTHER UnknownBIRTHPLACE OF MOTHER (City or town, State or foreign country) England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James A Fisk(ADDRESS) Macon MoFiled Sept 1, 1912 J. B. Banboch

REGISTRAR

## 3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug - 31, 1912  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug - 20, 1912, to Aug - 31, 1912, that I last saw him alive on Aug 31, 1912, and that death occurred, on the date stated above, at 2:40 pm.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
82A Softening of Brain  
82C  
10 3/4 (Duration) yrs. mos. 1 ds.

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

(Signed) C. R. Woodson M. D.  
Sept 1, 1912 (Address) 220 N 7th St

\*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. 10 ds. In the \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. State 47 yrs. \_\_\_ mos. \_\_\_ ds.Where was disease contracted If not at place of death? Macon Mo.Former or usual residence Macon Mo.PLACE OF BURIAL OR REMOVAL Macon Mo DATE OF BURIAL Sept 2, 1912UNDERTAKER HEATON-BEGOLE UND. CO., ADDRESS 224 So 8th St.By J. W. Harle

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, peritoneum*, 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 "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.)

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.

PLACE OF DEATH

County Buchanan  
 Township Washington  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_

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

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

Registration District No. 86 File No. 28838  
 Primary Registration District No. 5127 Registered No. 71  
 (NO. Woodson's Sanitarium St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

W. B. Fisk

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>widowed</u> (Write the word)
DATE OF BIRTH <u>Sept. 11</u> , 18 <u>35</u> (Month) (Day) (Year)		
AGE <u>76</u> yrs. <u>11</u> mos. <u>20</u> ds. If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>N. Y.</u>		
PARENTS	NAME OF FATHER <u>Jas. Fisk</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>England</u>	
	MAIDEN NAME OF MOTHER <u>Unknown</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>England</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jas. A. Fisk</u> (ADDRESS) <u>Macon, Mo.</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 31, 192  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 20, 192, to Aug. 31, 192, that I last saw him alive on Aug. 31, 192, and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH\* was as follows:  
Cerebral hemorrhage softening of brain vessel degeneration + any obstruction  
 (Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Vessel degeneration + obstruction  
 (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. Starke M. D.  
Sept. 1, 192 (Address) 220 N. 7th St.

\* 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) 11 days  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 11 ds.  
 Where was disease contracted if not at place of death? Don't know  
 Former or usual residence Macon Mo

PLACE OF BURIAL OR REMOVAL <u>Macon, Mo.</u>	DATE OF BURIAL <u>Sept. 2</u> 19 <u>2</u>
UNDERTAKER <u>W. Starke</u>	ADDRESS <u>227 So 8th St.</u>

Filed Mr. J. J. Baust REGISTRAR  
SEP 1912

Original file, date \_\_\_\_\_ All information called for must be written on this Supplementary Certificate.

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