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

PLACE OF DEATH

County: Worth

Township: Fletcher

or Village

Registration District No. 903

File No. 41903

Primary Registration District No. 6212

Registered No. 23

or City (No. St.; Ward)

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

FULL NAME Frank Cheney

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Male
COLOR OR RACE	White
SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)	widowed
DATE OF BIRTH (Month) (Day), (Year)	July 30, 1844
AGE	68 yrs. 4 mos. 8 ds.
If LESS than 1 day, hrs. or min.?	
OCCUPATION (a) Trade, profession, or particular kind of work	Retired
(b) General nature of industry, business, or establishment in which employed (or employer)	Butcher
BIRTHPLACE (City or town, State or foreign country)	Vt
PARENTS — NAME OF FATHER	Wayner Cheney
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Vt
MAIDEN NAME OF MOTHER	Lucy Temple
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Vt

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Conkley by O Prugh

(ADDRESS) Grant City Mo

Filed Dec 10 1912 John Andrews REGISTRAR

200

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 8 (Month) (Day), 1912 (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:

Sudden Death
Found dead in bed
Had no Physician

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

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

(Signed) ...... M. D.

......, 191... (Address) ......

*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	DATE OF BURIAL
Fletchall Cem	12-11 1912
UNDERTAKER	ADDRESS
O Prugh	Grant City

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

PLACE OF DEATH

County_____

Township_____ Registration District No._____ File No._____

or

Village_____ Primary Registration District No._____ Registered No._____

or

City _____ (NO._____, _____ St.; _____ Ward)

[If de... hospita... give f... of stree...

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1_____
(Month) (Day) (Year)

AGE

____ yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

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)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____
(Month) (Day)

I HEREBY CERTIFY, that I attended deceas...

_____, 191____, to _____, 19...

that I last saw h____ alive on _____, 19...

and that death occurred, on the date stated above, at...

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) ____ yrs. ____ mos.

Contributory _____
(Secondary)

_____ (Duration) ____ yrs. ____ mos.

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes (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.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE O...

UNDERTAKER | ADDRES...

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.)

(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 not paid *Housekeepers* who receive a definite salary) should be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Particulars should be taken to report specifically the occupations

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

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

PLACE OF DEATH

County Worth

Township Fletchall or Village or City

Registration District No. 903 Primary Registration District No. 6212

File No. Registered No. 23

(NO. St.; Ward)

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

FULL NAME Frank Cheney

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	widowed

DATE OF BIRTH July (Month) 30 (Day), 1844 (Year)

AGE 68 yrs. 4 mos. 8 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Butcher

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

BIRTHPLACE (City or town, State or foreign country) Vt.

PARENTS

NAME OF FATHER Wayner Cheney

BIRTHPLACE OF FATHER (City or town, State or foreign country) Vt.

MAIDEN NAME OF MOTHER Lucy Temple

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Vt.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John Conkley

(ADDRESS) Grant City, Mo.

Filed Feb 10, 1913 John Conkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 8 (Month) (Day), 1912 (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:

Sudden Death. Found dead in bed. Had no physician

(Duration) yrs. mos. ds.

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

I signed John Conkley M. D.

Feb 10 1913 (Address) Grant City

*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	DATE OF BURIAL
Fletchall Cem.	12-11-1912
UNDERTAKER	**ADDRESS**
O. Prugh	Grant City

Original file, date DEC 19 All information called for must be written on this Supplementary Certificate.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

[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, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles;* ~~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.)