

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

PLACE OF DEATH
County Dallas
Township Washington
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 247 File No. 31870
Primary Registration District No. 5342 Registered No. 18

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

FULL NAME Mary Ann Frazier

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Oct 3, 1914
(Month) (Day) (Year)

DATE OF BIRTH Nov 4, 1832
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 20, 1914, to Oct 3, 1914,
that I last saw her alive on Sept 29, 1914,

AGE 81 yrs. 10 mos. 29 ds.
If LESS than 1 day, _____ hrs. or _____ min.?

and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:

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

Internal injury
from fall
1860
1914

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

(Duration) _____ yrs. _____ mos. 18 ds.

PARENTS NAME OF FATHER Andrew Neel

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

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

(Signed) J. H. H. Reser M. D.
Oct 10, 1914 (Address) Conway Mo

MAIDEN NAME OF MOTHER Phoebe Hodges

*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) Tenn.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Clara Stallings

Where was disease contracted If not at place of death? _____
Former or usual residence _____

(ADDRESS) Conway

PLACE OF BURIAL OR REMOVAL Baptist Cemetery DATE OF BURIAL Oct 4, 1914

Filed Oct 12, 1914 J. H. H. Reser REGISTRAR

UNDERTAKER J. L. Anderson ADDRESS Conway Mo

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, 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, 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.)

PLACE OF DEATH

County

Township

or
Village

or

City

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

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO.

St.:

Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

DATE OF BIRTH

AGE

IF LESS than
1 day, ___ hrs.
or ___ min.
___ yrs. ___ mos. ___ ds.

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

1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

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 _____.

The CAUSE OF DEATH* was as follows:

Internal injury from fall. Fracture of ribs from accidental fall with internal injury (Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

(Signed) J. H. H. Regier M.D.
10/10 1914 (Address) Conway 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 _____ 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

UNDERTAKER

ADDRESS

Original file, date

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

Revised United States Standard Certificate of Death

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

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