

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.

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

PLACE OF DEATH
County Woods
Township _____
or
Village _____
or
City Marionville (NO. St. Francis Hospital) Ward _____
Registration District No. 625 File No. 32987
Primary Registration District No. 3031 Registered No. 96
FULL NAME Catherine Fox
(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 <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> (Write the word)	DATE OF DEATH <u>Oct 9</u> , 191 <u>4</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Aug 16</u> , 18 <u>38</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Sept 22</u> , 191 <u>4</u> , to <u>Oct 9</u> , 191 <u>4</u> , that I last saw her alive on <u>Oct 9</u> , 191 <u>4</u> , and that death occurred, on the date stated above, at <u>9:0</u> a.m.	
AGE <u>76</u> yrs. <u>1</u> mos. <u>13</u> ds.			The CAUSE OF DEATH* was as follows: <u>Hypostatic Pulmonary Congestion</u> <u>Prolonged dorsal decubitus</u> <u>111B</u> <u>153B</u> (Duration) _____ yrs. _____ mos. <u>21</u> ds. ✓	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			Contributory <u>Fracture of femur</u> (SECONDARY) (Duration) <u>1</u> yrs. <u>7</u> mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Ohio</u>			(Signed) <u>C. V. Martin</u> M. D. <u>Oct 9</u> , 191 <u>4</u> (Address) <u>Marionville Mo.</u>	
PARENTS	NAME OF FATHER <u>Jacob Rives</u>		*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 FATHER (City or town, State or foreign country) <u>Germany</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER <u>Neiverson</u>		At place of death _____ yrs. _____ mos. <u>10</u> ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>		Where was disease contracted if not at place of death? Former or usual residence <u>Ohio</u> <u>Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. F. Lager</u> (ADDRESS) <u>Clyde Ind.</u>			PLACE OF BURIAL OR REMOVAL <u>Clyde Mo</u>	
OCT 9 1914 REG. TRAR			DATE OF BURIAL <u>Oct 12</u> , 191 <u>4</u>	
			UNDERTAKER <u>Price & McNeal</u>	
			ADDRESS <u>Marionville Mo.</u>	

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, 8 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.)

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

PLACE OF DEATH
 County Madaway
 Township _____
 or Village _____
 or City Marysville

Registration District No. 625 File No. _____
 Primary Registration District No. 3031 Registered No. 96
 St. _____ Ward _____

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

FULL NAME Catherine Fox

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OF RACE W SINGLE MARRIED WIDOWED OR DIVORCED W
(Write the word)

DATE OF DEATH _____, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1914, to _____, 1914, that I last saw him _____, 1914, and that death occurred, on the date stated above at _____ m.

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

The CAUSE OF DEATH* was as follows:
Post mortem Pulmonary
emphysema Prolonged
Respiratory Decubitus.
accidental (Duration) _____ 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) _____

Contributory fracture of femur (Secondary) from fall (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. M. Martin (M.D.)
10/9/14 (Address) Marysville Mo.

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) _____

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

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

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 _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1914

403 Filed _____ 1914 REGISTRAR _____

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied

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