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

PLACE OF DEATH

County: Shelby

Township or Village or City: Tiger Fork — Registration District No. 1024 — File No. 2-7069

Primary Registration District No. 6088 — Registered No. 2

(NO. ____ St.: ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Martha Catherine Smoot

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word)
Female	White	✓

DATE OF BIRTH: Feb. (Month) 28 (Day), 1843 (Year)

AGE: 71 yrs. 10 mos. 20 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER: Daniel Hall
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Susannah Barron
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Howard Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Dan J. Smoot
(ADDRESS): Philadelphia Mo.

Filed Feb 25, 1915 — E. Calvert, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. (Month) 18 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 11, 1914, to Jan 18, 1915, that I last saw her alive on Jan 18, 1915, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) 01 yrs. ___ mos. 41 ds.

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

(Signed) H. F. Rhodes M. D.
Jan 18, 1915 (Address) Philadelphia 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 State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Bethany Cemetery — DATE OF BURIAL: Jan 20, 1915
UNDERTAKER: John Brothers — ADDRESS: Bethel Mo

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, peritonaeum*, 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 *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.)

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: Shelby

Township: Tiger Fork

or Village: ____

or City: ____ (No. ____ St.: ____ Ward)

Registration District No. 1024 File No. ____

Primary Registration District No. 6088 Registered No. 2

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

FULL NAME Martha Catherine Smoot.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: W

SINGLE / MARRIED / WIDOWED / DIVORCED (Write the word): W

DATE OF BIRTH: Feb 28, 1843 (Month) (Day) (Year)

AGE: 71 yrs. 10 mos. 20 ds. If LESS than 1 day, ____ hrs. or ____ min.

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

BIRTHPLACE (City or town, State or foreign country): Boone Co Mo

PARENTS
NAME OF FATHER: Daniel Hall
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Susan Bannon
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Howard Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan H. Smoot
(ADDRESS) Philadelphia Mo.

Filed Feb 25 1915 C. E. Calvert REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. 18, 1915 (Month) (Day) (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:
Typhoid Fever

(Duration) ____ yrs. ____ mos. 4 1/2 ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. F. Rhodes M. D.
Jan 18 1915 (Address) Philadelphia 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 State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death? ____
Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Bethany cemetery
DATE OF BURIAL: Jan 20 1915
UNDERTAKER: John Brothers
ADDRESS: Bethel Mo

SUPPLEMENTARY

Satisfactory Information Supplied

Original file, date Feb 25 1915 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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