

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

PLACE OF DEATH  
County Franklin  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Kennett Mo (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 288 File No. 8090  
Primary Registration District No. 4172 Registered No. 23

FULL NAME Matthew Thompson Fuller

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

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White ~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) married  
DATE OF BIRTH Nov 14, 1847  
(Month) (Day) (Year)

DATE OF DEATH 3/4, 1915  
(Month) (Day) (Year)

AGE 67 yrs. 3 mos. 18 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1914, to 3/4, 1915, that I last saw her alive on 3/11, 1915,

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

and that death occurred, on the date stated above, at 11 a. m.  
The CAUSE OF DEATH\* was as follows:

BIRTHPLACE (City or town, State or foreign country) Pittsburgh Pa

Chronic Malaria  
38 Bronchitis  
106 B  
(Duration) \_\_\_ yrs. 9 mos. 1 ds.

PARENTS  
NAME OF FATHER Wm. H. Fuller  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Pa  
MAIDEN NAME OF MOTHER Martha Thompson  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) James J. Dyer M. D. 3/4, 1915 (Address) Kennett Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Will Fuller  
(ADDRESS) Kennett Mo

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

Filed Mar 4, 1915 J. Rigdon REGISTRAR

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 Marsh Cem DATE OF BURIAL 3-5, 1915  
UNDERTAKER A. C. Lawdell ADDRESS Kennett Mo

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, 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, 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 "Astheno," "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

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

County St. Louis Registration District No. 288 File No. \_\_\_\_\_  
 or \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4172 Registered No. 23  
 or \_\_\_\_\_  
 Village \_\_\_\_\_  
 or \_\_\_\_\_  
 City Kenett MO (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 FULL NAME Matthew J. Fuller [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>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word) <u>M</u>
DATE OF BIRTH _____, 19____ (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) _____	

DATE OF DEATH 3/4, 1915  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred, on the date stated above, at 110 m.  
 The CAUSE OF DEATH\* was as follows:  
Chronic Mitral Aneurysm  
arrhythmia  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) J. J. Ryan M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*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) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_  
 Filed 3/4 1915 J. J. Ryan REGISTRAR

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 \_\_\_\_\_ 19\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY  
 Missouri State Board of Health  
 Bureau of Vital Statistics  
 St. Louis, Missouri

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

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