

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

PLACE OF DEATH

County Johnson
Township Jefferson
Village _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 14
Primary Registration District No. 5587

File No. 9059
Registered No. 5

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

FULL NAME

Enoch Callicotte

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH

April 7, 1828
(Month) (Day) (Year)

AGE

85 yrs. 11 mos. 13 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

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

BIRTHPLACE

(City or town, State or foreign country) Ohio

PARENTS

NAME OF FATHER Jordan Callicott

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

MAIDEN NAME OF MOTHER Unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Callicotte

(ADDRESS) Windsor Mo.

Filed

Ms 25 1915 E. J. Simmons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

March 24, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 15, 1915, to March 24, 1915, that I last saw him alive on March 23, 1915, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Emannic Poison

13/1526 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory

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

(Signed) E. J. Parsons M. D.
March 25, 1915 (Address) Lecton 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

High Point Cem.

DATE OF BURIAL

Mar. 26, 1915

UNDERTAKER

W. E. Huston

ADDRESS

Windsor Mo.

N. B.—Every item of information should be given in plain terms, so that it may be fully understood. Every important CAUSE OF DEATH in plain terms, so that it may be fully understood.

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, 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 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.)

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

CITIZANS of state

County Jefferson
Township Jefferson
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 14 File No. _____
Primary Registration District No. 5587 Registered No. 5

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

FULL NAME Enoch Calliootte

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 24, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h. _____, 191____,
and that death occurred, on the _____, 191____, at _____ m.

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

The CAUSE OF DEATH* was as follows:
Epidemic Typhus
Chronic Bright's Disease

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

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

BIRTHPLACE (City or town, State or foreign country) _____

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

NAME OF FATHER _____

(Signed) W. J. P. P. P. M. D.
3-20-15 (Address) Perton Mo.

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.

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 _____

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

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

Filed May 10, 1915 R. J. Jennings REGISTRAR

UNDERTAKER _____ ADDRESS _____

be carefully supplied. AGE should be stated EXACTLY.

Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.

Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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