

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

PLACE OF DEATH

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

Registration District No. 183 File No. 27404

Primary Registration District No. 5254 Registered No. 11

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

FULL NAME Opha Chloe Fox

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single
DATE OF BIRTH May 16, 1914
(Month) (Day) (Year)

DATE OF DEATH July 6, 1916
(Month) (Day) (Year)

AGE 2 yrs. 1 mos. 21 ds. If LESS than 1 day, ___ hrs. or ___ min.?

I HEREBY CERTIFY, that I attended deceased from June 15, 1916, to July 6, 1916, that I last saw her alive on July 6, 1916, and that death occurred, on the date stated above, at 11 a. m.

OCCUPATION (a) Trade, profession, or particular kind of work _____

The CAUSE OF DEATH* was as follows:
Meningitis

(b) General nature of industry, business, or establishment in which employed (or employer) _____

38
79A (Duration) ___ yrs. ___ mos. 7 ds.

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

Contributory Malaria (SECONDARY) (Duration) ___ yrs. ___ mos. 15 ds.

PARENTS NAME OF FATHER Joe F Fox BIRTHPLACE OF FATHER (City or town, State or foreign country) France

(Signed) L. W. Fowler M. D. July 7, 1916 (Address) Nixa Mo

MAIDEN NAME OF MOTHER Addie Bolin

*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) Mo

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

Where was disease contracted if not at place of death? _____

(Informant) J. M. Bolin

Former or usual residence _____

(ADDRESS) Nixa Mo

PLACE OF BURIAL OR REMOVAL Christian County DATE OF BURIAL July 7, 1916

Filed Aug 12, 1916 Alex. West

UNDERTAKER J. B. Hanson ADDRESS Ozark Mo

REGISTRAR

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, 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.)

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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Township

Village

City

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

Registration District No.

Primary Registration District No.

File No.

Registered No.

NO

St.

Ward)

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

16 DATE OF DEATH

6 DATE OF BIRTH

7 AGE

If LESS than
1 day.....hrs.
or.....min.?

17 I HEREBY CERTIFY, that I attended deceased from
June 15, 1916, to July 6, 1916,
that I last saw her alive on July 5, 1916,
and that death occurred, on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

8 OCCUPATION
(a) Trade, profession, or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(City or town,
State or foreign country)

10 NAME OF
FATHER

11 BIRTHPLACE
OF FATHER

12 MAIDEN NAME
OF MOTHER

13 BIRTHPLACE
OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

AUG 1916

Registrar

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. W. Fambro M. D.

July 1916 (Address) Nixa Mo.

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

18 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

19 PLACE OF BURIAL OR REMOVAL

20 DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Original file, date

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

Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' PHYSICIAN'S
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Supplementary Certificate

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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), *29ds.*; *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 septicæmia, 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.)

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