

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH 40287

1 PLACE OF DEATH

County Cedar

Township \_\_\_\_\_

Village \_\_\_\_\_

City Eldorado 870

Registration District No. 168

File No. \_\_\_\_\_

Primary Registration District No. 4095

Registered No. 74

2 FULL NAME Frankie E. Howard

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED widow  
(Write the word)

6 DATE OF BIRTH Dec 27 1885  
(Month) (Day) (Year)

7 AGE 80 yrs. mos. da. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife 25  
(b) General nature of industry business or establishment in which employed (or employer) 24A 173A

9 BIRTHPLACE (City or town, State or foreign country) Ind

PARENTS  
10 NAME OF FATHER Jim Foster  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio  
12 MAIDEN NAME OF MOTHER Foster  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Ed Leeper  
(Address) \_\_\_\_\_

15 Filed 12 15 1916 W. Dawson  
Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 14 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 29 1916 to Oct 29 1916, that I last saw her alive on Oct 29 1916, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH\* was as follows:  
Tuberculosis of Brain and intestines 20  
Unknown (Duration) yrs. mos. da.

CONTRIBUTORY Unknown (Secondary) (Duration) yrs. mos. da.  
(Signed) W. H. Hoyster M. D.  
Dec 14 1916 (Address) Eldorado Ohio

\*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. da. In the State yrs. mos. da.  
Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Eldorado DATE OF BURIAL 12 16 1916

20 UNDERTAKER W. H. Hoyster ADDRESS Eldorado

# 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 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.)

1916  
67  
350

## 1 PLACE OF DEATH

County

Cedar

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

Township

Registration District No.

File No.

Village

Primary Registration District No.

Registered No.

City

(NO

St.

Ward)

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

2 FULL NAME

Francis E. Howard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH	If LESS than 1 day.....hrs. or.....min.?	
7 AGE	.....yrs.....mos.....ds.	

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)

PARENTS	10 NAME OF FATHER
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
	12 MAIDEN NAME OF MOTHER
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

11 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Sue Lecher

(Address)

El Dorado Mo

Filed 22 1917

W. D. Dawson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Dec 14 1916  
(Month) (Day) (Year)

17 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 .....

The CAUSE OF DEATH\* was as follows:

Tuberculosis of Brain  
and Intestines causing  
Perforation of Bowels  
..... (Duration) ..... yrs. 6 mos. .... ds.

CONTRIBUTORY

(Secondary)

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

(Signed) ..... M. D.

..... 191..... (Address) .....

\*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

DATE OF BURIAL

Johnston Mo 12 16 1916

20 UNDERTAKER

ADDRESS

W. A. Stephens El Dorado Mo

Original file, date DEC 1916, 19.....

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

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