

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

1 PLACE OF DEATH

County Marion  
Township Mason  
or  
Village  
or  
City Hambel (NO. 2015 10th St.: 3 Ward)

Registration District No. 547 File No. 22688

Primary Registration District No. 3079 Registered No. 210

2 FULL NAME Frank William Foster

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Mar 31 1849  
(Month) (Day) (Year)

AGE 68 yrs. 2 mos. 26 ds. If LESS than 1 day.....hrs. or.....min.?

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

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

10 NAME OF FATHER James Foster

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Nova Scotia

12 MAIDEN NAME OF MOTHER Johanna Browning

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Nova Scotia

4 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Mildred Foster  
(Address) Hambel

5 Filed June 30 1917 Thos B Arnold Registrar  
104 Deputy

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 15 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 15 1917 to June 27 1917, that I last saw him alive on June 25 1917 and that death occurred, on the date stated above, at 6:40 a.m.

The CAUSE OF DEATH\* was as follows:  
Organic Heart disease

(Duration) 4 yrs. 9 mos. 9 ds.

CONTRIBUTORY arteriosclerosis  
(Secondary) (Duration) 4 yrs. 9 mos. 9 ds.

(Signed) W. C. [Signature] M. D.  
June 28 1917 (Address) Hambel 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 Foster Cem. DATE OF BURIAL June 29 1917

20 UNDERTAKER Thos. M. Smith ADDRESS Hambel

# 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.)

County MarionREGISTRARS SHALL NOT RECEIVE  
A FEE FOR CERTIFICATES UNTIL THEY  
ARE COMPLETED AS PRESCRIBED BY  
LAW

Township .....

Registration District No. 547

File No. ....

Village .....

Primary Registration District No. 3029Registered No. 210City Nannibal

(NO. .... St. .... Ward)

[If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number.]2 FULL NAME Frank William Foster

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE  
MARRIED Married  
WIDOWED  
OR DIVORCED  
(Write the word)6 DATE OF BIRTH  
Satisfactory Information Supplied  
(Month) ..... (Day) ..... 1 ..... (Year) .....7 AGE  
Satisfactory Information Supplied  
..... yrs. .... mos. .... ds. IF LESS than  
1 day ..... hrs.  
or ..... min.?8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work Retired Clerk  
(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) .....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 Filed June 30 1917 Thos B Arnold  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28 1917  
(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..... m.

The CAUSE OF DEATH\* was as follows:

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

CONTRIBUTORY  
(Secondary) .....

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

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

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

\*State the Disease Causing Death, or, in death 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

20 UNDERTAKER Tom M Smith Nannibal, Mo.  
ADDRESSOriginal file, date June 30, 1917

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

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