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

PLACE OF DEATH

County Stone

Township or Village Galena or City (NO. , St.: Ward)

Registration District No. 843

Primary Registration District No. 45-13

File No. 4031

Registered No.

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

FULL NAME Hannibal Fox.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Oct 18th 1839, (Month) (Day) (Year)

AGE: 78 yrs. one mos. 7 ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Vermont

PARENTS

NAME OF FATHER: Thomas Fox.

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

MAIDEN NAME OF MOTHER: Clarissa Merrill

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hannibal Fox

(ADDRESS) Galena Mo.

Filed Dec 1, 1917. L. Henson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Hannibal Fox, 1917 Nov (Month) 25 (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 10, 1917, to Nov 25, 1917, that I last saw him alive on Nov 25, 1917, and that death occurred, on the date stated above, at 11:00 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

135B

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) R. F. Hulett M. D.

Nov 25 1917 (Address) Galena 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: Galena Cemetery

DATE OF BURIAL: Nov. 27, 1917

UNDERTAKER: Craig Mrc. Co.

ADDRESS: Galena Mo.

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CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City ..... (NO. ..... , ... St.; ..... Ward)

[If d
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FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ..... 191..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....
(Month) (

I HEREBY CERTIFY, that I attended d

....., 191....., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated above,

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mo

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mo

(Signed).....

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

*State the Disease Causing Death, or, in deaths from Viole
(1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicida

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, T
RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....r

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF E
UNDERTAKER	ADDRESS

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.)

NOTE.—Individual offices may add to above list of undesir-

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