

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

23500  
756

SEP 26 1927

1. PLACE OF DEATH

County Andrew  
Township  
City Savannah,

Registration District No. 13  
Primary Registration District No. 4010  
(No. Dr. Nichols Sanitorium)

File No.  
Registered No. St. Ward

2. FULL NAME Fannie Emmaline Hannah,

(a) Residence. No. St. Ward, Texline, Texas.  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 20 mos. 19 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married,

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Hannah,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 30, 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
46 10 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home,  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Francisco,  
(STATE OR COUNTRY) Indiana,

10. NAME OF FATHER Elias Dill,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown,  
(STATE OR COUNTRY) Unknown,

12. MAIDEN NAME OF MOTHER Elizabeth Wilkins,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,  
(STATE OR COUNTRY) Unknown,

14. INFORMANT William Hannah  
(Address) Texline, Texas.

15. Aug 27 27 W. J. J. J.  
Filed 19... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 25 1927

17. I HEREBY CERTIFY That I attended deceased from Aug 6, 1927, to Aug 25, 1927 that I last saw her alive on Aug 25, 1927, and that death occurred, on the date stated above, at 2:30 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Surgical shock following  
amputation of left arm  
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Thrombosis Brachial artery  
(duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

✓ DID AN OPERATION PRECEDE DEATH? yes - DATE OF Aug 22 1927

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical findings  
(Signed) W. J. J. J. M. D.

8/25, 1927 (Address) Savannah Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Texline, Texas, DATE OF BURIAL Aug. 28, 1927

20. UNDERTAKER Frank A. Bowman ADDRESS Savannah, Mo.

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.

PERMANENT RECORD

WITH UNFADING INK—THIS IS

PAINLY, WITH UNFADING INK—THIS IS

PARENTS

# 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 (d) 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; Broncho-pneumonia* ("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 neoplasm); *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.; Broncho-pneumonia* (secondary), *10ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, crystalpelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Andrew County

Registration Dist. 13

File No. 7

City Savannah,

Primary Reg. No. 4010

Reg. No. 56

Fannie Emmaline Hannah

Death August, 25 1927

Cause of death was Non- puerperal.



C. O. Jefferies, M. D.  
Local Registrar.

S-23500

requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: Fannie Emmaline Hammah

Who died at: Savannah, Ga. on Aug. 25, 1927

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

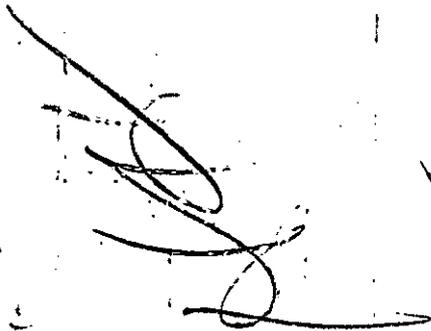
Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: surgical shock following amputation of left arm

Contributory: Thrombosis Brachial artery.

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A large, stylized handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke at the bottom.