

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

PLACE OF DEATH
County Montgomery
Township _____
or
Village _____
or
City Wellsville (NO. _____ St.: _____ Ward)

Registration District No. 895 File No. 11299
Primary Registration District No. 4353 Registered No. _____

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

FULL NAME Thomas Fox

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Mar 3, 1917
(Month) (Day) (Year)

DATE OF BIRTH Mar 3, 1839
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 2, 1917, to Mar 3, 1917, that I last saw him alive on Mar 3, 1917, and that death occurred, on the date stated above, at 4:30 m.

AGE 73 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH was as follows:
Opoplexy, Cerebral

OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1-67

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

BIRTHPLACE (City or town, State or foreign country) Albany N.Y.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER Fox

(Signed) [Signature] M. D.

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

MAIDEN NAME OF MOTHER Unknown

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

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.

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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

PLACE OF BURIAL OR REMOVAL Wellsville DATE OF BURIAL Mar 4, 1917

(Informant) Felix Fox

UNDERTAKER Keelley Wells ADDRESS Wellsville Ky

(ADDRESS) Wellsville

Filed Mar 3, 1917 E. Asherson 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*, *Composer*, *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, meningēs, peritonacum*, etc., *Carcinoma*, *Sar-*

coma, 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 Montgomery

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

Township _____ or _____ City Wellsville (NO. _____ St. _____ Ward _____)
Registration District No. 5895 File No. 11299
Primary Registration District No. 4353 Registered No. 10

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

FULL NAME Thomas Fox

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) married

DATE OF BIRTH Mar. 3, 1839
(Month) (Day) (Year)

AGE 72 yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

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

BIRTHPLACE (City or town, State or foreign country) Albany n. y.

PARENTS
NAME OF FATHER John Fox
BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
MAIDEN NAME OF MOTHER Slintensown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Drylon Fox
(ADDRESS) Wellsville Mo.

File Mar 5 1911 REGISTRAR E. O. Kuroyan

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 3, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 2, 1911, to Mar 3, 1911, that I last saw him alive on Mar 3, 1911, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:
Apoplexy, Cerebral

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. O. Kuroyan M. D.
Mar 5, 1911 (Address) Wellsville 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 Wellsville Mo DATE OF BURIAL Mar. 4, 1911
UNDERTAKER Reeling Wells ADDRESS Wellsville Mo

Revised United States Standard Certificate of Death

[[Approved by U. S. Census and American Public Health
Association]]

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