

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Monroe

Township _____

or
Village _____or
City Paris (NO. _____) St. _____ Ward _____Registration District No. 582File No. 72049Primary Registration District No. 4344Registered No. 22

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

FULL NAME Celia Fitzpatrick

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White MARRIAGE STATUS Married
(Write the word)DATE OF BIRTH January 9, 1865
(Month) (Day) (Year)AGE 44 yrs. 2 mos. 2 ds. IF LESS than 1 day, ___ hrs. or ___ min.?OCCUPATION
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0BIRTHPLACE Westmorland Co Pennsylvania
(City or town, State or foreign country)PARENTS
NAME OF FATHER John W. Fitzpatrick
BIRTHPLACE OF FATHER Westboro Pa Pennsylvania
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Hattie W. Fitzpatrick
BIRTHPLACE OF MOTHER Somer set Co Penna.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Chisney
(ADDRESS) Shelburne MoFiled Jan 12, 1912 J. H. Paegle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 11, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan 1, 1912, to Jan 11, 1912 that I last saw him alive on Jan 11, 1912 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
2311Contributory (SECONDARY) None
(Duration) ___ yrs. ___ mos. ___ ds.(Signed) J. H. Paegle M. D.
Jan 12, 1912 (Address) Paris 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

Shelburne Mo

DATE OF BURIAL

Jan 13, 1912

UNDERTAKER

Geo F Speed

ADDRESS

Paris Mo

PROPERTY UNRESERVED. 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*, *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, peritoneum*, 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.)



PLACE OF DEATH

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

County Monroe Registration District No. 582 File No. 71 2049
Township _____ or _____ Village _____ or _____ City Paris (NO. _____) (St. _____) (Ward _____)
Primary Registration District No. 4344 Registered No. 2

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

FULL NAME

Celia Fitzpatrick

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED married WIDOWED OR DIVORCED
(Write the word)
DATE OF BIRTH Jan 9, 1868
(Month) (Day) (Year)
AGE 44 yrs. 2 mos. 2 ds.
IF LESS than 1 day, _____ hrs. or _____ min.

DATE OF DEATH Jan 11, 1912
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Jan 1, 1912, to Jan 11, 1912
that I last saw her alive on Jan 11, 1912,
and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

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

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

(Signed) H. O. Payne M. D.
Jan 12 1912 (Address) Paris 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 Shelbina Mo DATE OF BURIAL Jan 13 1912

UNDERTAKER Joe F Speed ADDRESS Paris Mo

OCCUPATION (a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
BIRTHPLACE (City or town, State or foreign country) Penn
NAME OF FATHER John Way
BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn
MAIDEN NAME OF MOTHER Battie Way
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Penn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Way
(ADDRESS) Shelbina Mo
Filed Jan 12 1912 H. O. Payne REGISTRAR

Original file, date Jan 12 1912 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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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.)