

FOR BINDING

WRITE PLAINLY, WITH INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH  
County Linn  
Township Locust Creek  
or  
Village \_\_\_\_\_  
or  
City Linneus Mo. (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 501 File No. 30010  
Primary Registration District No. 566 Registered No. 14

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

FULL NAME Eben. B. Foster

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	MARRIAGE STATUS <u>widowed</u>	
DATE OF BIRTH <u>July 26, 1835</u> (Month) (Day) (Year)			
AGE <u>77</u> yrs. <u>2</u> mos. <u>9</u> ds. If LESS than 1 day, _____ hrs. or _____ min.?			
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-02</u>			
BIRTHPLACE (City or town, State or foreign country) <u>N.H.</u>			
PARENTS	NAME OF FATHER <u>John Foster</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't Know</u>		
	MAIDEN NAME OF MOTHER <u>Brown</u>		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't Know</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. M. C. Henry</u> (ADDRESS) <u>Linneus Mo.</u>			
Filed <u>Sept 6, 1912</u> REGISTRAR <u>V. C. Travers</u>			

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Sept. 6, 1912</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Aug. 24, 1912</u> , to <u>Sept. 6, 1912</u> , that I last saw him alive on <u>Sept. 5, 1912</u> , and that death occurred, on the date stated above, at <u>3:30 p.m.</u>	
The CAUSE OF DEATH* was as follows: <u>Diarrhoea</u> <u>92A</u> <u>120B</u>	
(Duration) _____ yrs. _____ mos. <u>14</u> ds.	
Contributory (SECONDARY) <u>Mitral regurgitation</u> (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>W. R. Williams</u> M. D. <u>Sept. 6, 1912</u> (Address) <u>Linneus Mo.</u>	
*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 <u>Cawker City Kans.</u>	DATE OF BURIAL <u>9/9/12, 1912</u>
UNDERTAKER <u>V. C. Travers</u>	ADDRESS <u>Linneus Mo.</u>

# 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.)



## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

## PLACE OF DEATH

County LinnTownship Locust Creek

Village \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_)

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

Registration District No. 501Primary Registration District No. 5666File No. 30010Registered No. 14

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

## FULL NAME

Eben B. Foster

## PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widowed  
(Write the word)DATE OF BIRTH July 26, 1885  
(Month) (Day) (Year)AGE 77 yrs. 2 mos. 9 ds. if LESS than 1 day, hrs. or min.OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_BIRTHPLACE (City or town, State or foreign country) N. H. LEMMONNAME OF FATHER John FosterBIRTHPLACE OF FATHER (City or town, State or foreign country) don't knowMAIDEN NAME OF MOTHER Margaret BrownBIRTHPLACE OF MOTHER (City or town, State or foreign country) don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. D. O. McKee(ADDRESS) Linneus, Mo.Filed Nov 10, 1912 W. C. Travers REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 6, 1912  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug. 24, 1912, to Sept. 6, 1912  
that I last saw him alive on Sept. 5, 1912  
and that death occurred, on the date stated above, at 330 a. m.

The CAUSE OF DEATH\* was as follows:

Diarrhea  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory mitral regurgitation  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) W. T. Adams M. D.  
Sept. 6, 1912 (Address) Linneus, 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 Cawker City Kans. DATE OF BURIAL 9-9, 1912UNDERTAKER W. C. Travers ADDRESS Linneus Mo.Original file, date SEP 19

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

MARGIN RESERVE IK—THIS IS

N. D.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, as very classified. Exact statement of OCCUPATION is very important.

UNFADING INK—PAGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, as very classified. Exact statement of OCCUPATION is very important.

V. S. No. 2.

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