

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

583

1 PLACE OF DEATH  
County *Carroll*  
Township *Eugene*  
or  
Village  
or  
City (NO St. Ward)

Registration District No. *942* File No.  
Primary Registration District No. *5201* Registered No.

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

2 FULL NAME *Francis O. Brooker*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *married*

6 DATE OF BIRTH *March 25 1859*  
(Month) (Day) (Year)

7 AGE *56 yrs 9 mos 30 ds.* If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *Adams Co. Ohio*

PARENTS  
10 NAME OF FATHER *Joseph Pence*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Adams Co. O.*  
12 MAIDEN NAME OF MOTHER *Hariett Dryden*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Brown Co. O.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Joseph Pence*  
(Address) *Wakenda, Mo.*

15 Filed *Jan 25 1916*  
Registrar

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *January 24 1916*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *April 1914* to *Jan 24 1916*, that I last saw her alive on *Jan 11 1916*, and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH\* was as follows:  
*Carcinoma of Breast*  
*50*  
(Duration) *14 2* mos. *2* ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *J. E. Tange* M. D. *Jan 25 1916* (Address) *Wakenda Mo.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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.....

19 PLACE OF BURIAL OR REMOVAL *Oak Hill Cem.* DATE OF BURIAL *Jan 26 1916*

20 UNDERTAKER *J. E. Willis* ADDRESS *Carrollton Mo.*

# 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, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, 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.)

1 PLACE OF DEATH  
 County Carroll  
 Township Eugene  
 or  
 Village  
 or  
 City

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

Registration District No. 942 File No. ....

Primary Registration District No. 0201 Registered No. ....

(NO. ....) (St. ....) (Ward ....)

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

2 FULL NAME Francis O. Brookover

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX F 4 COLOR OF RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M.

6 DATE OF BIRTH February 1 (Month) (Day) (Year)

7 AGE 3 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS  
 10 NAME OF FATHER  
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country)  
 12 MAIDEN NAME OF MOTHER  
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)

15 Filed Jan 25, 1916 J. H. George Registrar

16 DATE OF DEATH Jan. 24, 1916 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 191... to ..... 191... that I last saw h... alive on ..... 191... and that death occurred, on the date stated above, at ..... m. The CAUSE OF DEATH\* was as follows:

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

CONTRIBUTORY (Secondary) (Duration) ..... yrs. .... mos. .... ds. (Signed) ..... M. D. .... 191... (Address).....

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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.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL ..... 191...

20 UNDERTAKER ADDRESS

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