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

PLACE OF DEATH

County: Shelby

Township or Village or City: ~~Blackcreek~~ Shelbyville (NO. ____ St.; ____ Ward)

Registration District No. 831 — File No. 33251

Primary Registration District No. 4504 — Registered No. 25

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

FULL NAME: Paul W. Fayn

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Nov. 15, 1878 (Month) (Day) (Year)

AGE: 37 yrs. 9 mos. 29 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Life Insurance Agt.
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS

NAME OF FATHER: Saml Fayn

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

MAIDEN NAME OF MOTHER: Martha Ehler

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs. P. W. Fayn

(ADDRESS): Chillicothe, Mo.

Filed Sept 15, 1916. Wm Carson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: September 13, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept-13, 1916, to Sept-13, 1916, that I last saw him alive on Sept-13, 1916, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Overdoses of Drug, Taken Accidentally

1794 (Duration) Brief yrs. ____ mos. ____ ds.

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

(Signed) Geo. E. Forr M. D.

Sept-13, 1916 (Address) Shelbyville 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: Shelbyville I.O.D.F.

DATE OF BURIAL: Sept. 15, 1916

UNDERTAKER: J. W. Thompson Son

ADDRESS: Shelbyville, Mo.

MISSOURI STATE BOARD OF H

BUREAU OF VITAL STATISTI

CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ St.; _____ Ward) [If dea hospital give its of street

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____ (Month) (Day) (Year)

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

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

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

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) (D

I HEREBY CERTIFY, that I attended d _____, 191__, to _____ that I last saw h _____ alive on _____ and that death occurred, on the date stated above, The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ m

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ m

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Vio (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homici

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF
UNDERTAKER	ADDRESS

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 child-

(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