

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

PLACE OF DEATH

County Morgan  
Township Moureaux  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 594 File No. 2 2267

Primary Registration District No. 4354 a Registered No. 597

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

FULL NAME Francis Marian Strong

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH April 27, 1837  
(Month) (Day) (Year)

AGE 79 yrs. 7 mos. 9 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) Cole Co. Missouri

PARENTS  
NAME OF FATHER Martin Strong  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee  
MAIDEN NAME OF MOTHER Margaret Scribner  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Barthelemy Strong  
(ADDRESS) Barnett Mo

Filed 1/5 1917, W. L. Hadler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 8, 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January 4, 1917, to Jan 8, 1917, that I last saw him alive on Jan 8, 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:  
Cerebral Hemorrhage  
9217 1/64  
(Duration) \_\_\_ yrs. \_\_\_ mos. 4 ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) W. J. Wheat M. D.  
Jan 8, 1917 (Address) Barnett 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 N. A. Youns DATE OF BURIAL Jan 9, 1917  
UNDERTAKER Hope Well ADDRESS Barnett Mo

RESERVED FOR BINDING

READING INK—THIS IS A PERMANENT RECORD

Fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. Exact statement of OCCUPATION is very important. N. B.—Every item should be properly classified.

# 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.)



1 PLACE OF DEATH

County Morgan  
 Township Morgan  
 or  
 Village  
 or  
 City (NO. St. Ward)

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

Registration District No. 597 File No. a  
 Primary Registration District No. 4354 Registered No. 2

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

2 FULL NAME Francis Marian Strong

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE (yrs. mos. 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)

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

15 Filed 3/9 1917 W L Hatler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) (Year) Jan 8 1917

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) (Year) 191 to (Month) (Day) (Year) 191 that I last saw him/her alive on (Month) (Day) (Year) 191 and that death occurred on the date stated above, at (Month) (Day) (Year) (City or town, State or foreign country) m.

The CAUSE OF DEATH was as follows: Cerebral hemorrhage  
cause unknown  
 (Duration) (yrs. mos. ds.) 4 ds.

CONTRIBUTORY (Secondary) (Duration) (yrs. mos. ds.) (Signed) W J Barnett M.D. (Address) Barnett 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 Hopewell DATE OF BURIAL 1/9 1917

20 UNDERTAKER W A Gaus ADDRESS Barnett Mo.

SUPPLEMENTARY CERTIFICATE

WRITE PLAINLY, WITH UN-

Every 1/4 inch margin supplied. AGE should be stated EXACTLY. PHYSICIANS should state information could be obtained from informant. Exact statement of OCCUPATION is very important. DEATH in plain text so that it is

# Revised United States Standard Certificate of Death

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