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 Davies

Township Jamesport or Village Jamesport or City _____ (NO. _____ St. _____ Ward)

Registration District No. 252 File No. 33786

Primary Registration District No. 4152 Registered No. 16

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

FULL NAME Sarah A Kesler

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH January 17 (Month) (Day) 1846 (Year)

AGE 64 yrs. 10 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Sinking Springs Pa

PARENTS
NAME OF FATHER John Funk
BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.
MAIDEN NAME OF MOTHER Colringa Crum
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sinking Springs Pa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E A Kesler

(ADDRESS) Jamesport Mo

Filed Nov 26 1910 C E McKinley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November 18 (Month) (Day) 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from March 5, 1910, to Nov 17, 1910, that I last saw her alive on Nov 17, 1910, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Valvular heart Disease
92 A

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

Contributory (SECONDARY) _____

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

(Signed) O. F. Clagett M. D.

Nov 19 1910 (Address) Jamesport 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 _____ DATE OF BURIAL _____ 191__

UNDERTAKER _____ ADDRESS _____

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, 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 *septichaemia,*" "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.)

HUGH STEPHENS, JEFFERSON CITY.

PLACE OF DEATH

County Davies

Township or Village or City Jamesport

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

Registration District No. 252 File No. 33786

Primary Registration District No. 4152 Registered No. 16

(NO. ____ St.: ____ Ward)

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

FULL NAME Sarrah A. Kesler

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH January (Month) 17 (Day), 1846 (Year)

AGE 64 yrs. 10 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Sinking Springs O

PARENTS
NAME OF FATHER John Parelt
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee
MAIDEN NAME OF MOTHER Alsinga Drum
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sinking Springs O

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Kesler

(ADDRESS) Jamesport, Mo

Filed Nov 26 1910 C. G. McKinley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November (Month) 18 (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from March 5, 1910, to Nov. 17, 1910, that I last saw her alive on Nov. 17, 1910, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Valvular heart Disease

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

Contributory (SECONDARY) ___

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

(Signed) O. F. Clagett M. D.

Nov. 19 1910 (Address) Jamesport, 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 I. O. O. F. Cemetery X

DATE OF BURIAL Nov 19 1910 X

UNDERTAKER J. O. Burren X

ADDRESS Jamesport Mo X

SUPPLEMENTARY

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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