

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

PLACE OF DEATH

County Cape Girardeau

Township _____

or Village _____

or City Jackson (NO. _____) St. 3^d Ward

Registration District No. 127

Primary Registration District No. 4070

File No. 9641

Registered No. _____

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

FULL NAME Marietta Francis Grant

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX female COLOR OR RACE Caucasian SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(If write the word)

DATE OF BIRTH September 15th, 1843
(Month) (Day) (Year)

AGE 66 yrs. 11 mos. ___ ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

BIRTHPLACE (City or town, State or foreign country) S Lowell Mass.

PARENTS
NAME OF FATHER Justin Kent
BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
MAIDEN NAME OF MOTHER Do not know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Do not know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarena L. Grant

(ADDRESS) Jackson Mo.

Filed McK. 6th 1911 REGISTRAR

DATE OF DEATH August 15th, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 8th, 1908, to Aug. 15th, 1910, that I last saw her alive on Aug. 15th, 1910, and that death occurred, on the date stated above, at 10. A.M.

The CAUSE OF DEATH* was as follows:
Convulsions (Uremic)
Due to Chronic Parenchymatous Nephritis - under observation about (Duration) 2 yrs. 5 mos. 7 ds.

Contributory 131
(SECONDARY): 132 A Duration 1 yrs. 0 mos. 0 ds.

(Signed) J. W. Vinyard M. D.
Aug 16 1910 (Address) Jackson 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 City Cemetery Jackson DATE OF BURIAL Aug 16th, 1910

UNDERTAKER W. J. Tobler ADDRESS Jackson Mo.

RECORD OF DEATH IN BIRTH FORMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

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.)



This form should be filled out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
County Cape Girardeau
Township _____
or _____
Village _____
or _____
City Jackson (NO. _____) St. 3d Ward)

Registration District No. 127 File No. 9641

Primary Registration District No. 4070 Registered No. _____

FULL NAME Harriet Francis Grant

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Caucasian SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)

DATE OF DEATH August 15, 1910
(Month) (Day) (Year)

DATE OF BIRTH September 5, 1845
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 28, 1908, to Aug 15, 1910, that I last saw her alive on Aug 13, 1910, and that death occurred, on the date stated above, at 10 a. m.

AGE 66 yrs. 11 mos. - ds. If LESS than 1 day, - hrs. or - min.?

The CAUSE OF DEATH* was as follows:
Convulsions (Uremic)
due to Chronic parenchymatous nephritis under observation
about (Duration) 2 yrs. 5 mos. 7 ds.

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. W. Vinyard M. D.
Aug 16, 1910 (Address) Jackson Mo.

BIRTHPLACE (City or town, State or foreign country) Lowell, Mass.

PARENTS:
NAME OF FATHER Justin Grant
BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
MAIDEN NAME OF MOTHER do not know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) do not know

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence L Grant
(ADDRESS) Jackson, Mo

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 _____

Filed March 6, 1911 F. Brau REGISTRAR

PLACE OF BURIAL OR REMOVAL City Cemetery Jackson Mo DATE OF BURIAL Aug 16, 1910
UNDERTAKER E. J. Tobler ADDRESS Jackson Mo.

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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