

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 Jackson
Township Independence
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 288
Primary Registration District No. 5406

File No. 41034
Registered No. 156

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

FULL NAME Anna Jenkins

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
DATE OF BIRTH <u>Oct 7, 1858</u> (Month) (Day) (Year)		
AGE <u>53</u> yrs. <u>1</u> mos. <u>1</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeping</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

V MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 8, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from her attack by Physician, 1911, that I last saw her alive on _____, 1911, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
By simple Heart failure

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

PARENTS	NAME OF FATHER <u>Horris William</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tenn</u>
	MAIDEN NAME OF MOTHER <u>Iddy Bray</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn</u>

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

(Signed) Dr. J. E. Conner M. D.
12/9, 1911 (Address) Kennett, Mo.

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

(ADDRESS) Byrds. Mo
Filed Dec 9, 1911, T. J. Rigdon REGISTRAR

*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 <u>Senath Cemetery</u>	DATE OF BURIAL <u>12-10-1911</u>
UNDERTAKER <u>Lutz Fur. Co.</u>	ADDRESS <u>Kennett, Mo.</u>

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, 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.)



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

CERTIFICATE OF DEATH

PLACE OF DEATH
 County Greene
 Township Independence
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 788 File No. 41034
 Primary Registration District No. 5406 Registered No. 136

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

FULL NAME Anna Jenkins

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F. COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W
(Write the word)

DATE OF DEATH _____, 191____
(Month) (Day) (Year)

DATE OF BIRTH 10/7, 1888
(Month) (Day) (Year)

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 _____.

AGE 53 yrs. 1 mos. 1 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

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

Chronic Valvular Heart disease

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

(Duration) _____ yrs. 6 mos. _____ ds.

NAME OF FATHER Marion Williams

Contributory Lobar Pneumonia
(SECONDARY)

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo. Williams

(Duration) _____ yrs. _____ mos. 20 ds.
 (Signed) J. H. Rigdon M.D.
Feb 8 1912 (Address) Coroner Bennett

MAIDEN NAME OF MOTHER Esther Bray

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo. Williams

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENCES)

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

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

(ADDRESS) Burgs

Where was disease contracted If not at place of death?

Former or usual residence _____

Filed Feb 8 1912 J. H. Rigdon REGISTRAR

PLACE OF BURIAL OR REMOVAL Senath Cem. DATE OF BURIAL 12-10 1911

UNDERTAKER Leutz Fun. Co. Bennett

Original file, date DEC 8 1911, 19____

Revised United States Standard Certificate of Death

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

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