

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PLACE OF DEATH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County DeKalb
Township E. Benning
or
Village Forestland
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 878 File No. 1 3945
Primary Registration District No. 6203 Registered No. 2

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

FULL NAME Rebekah Jones Jones

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> <small>(Write the word)</small>	DATE OF DEATH <u>Jan 17</u> , 191 <u>2</u> <small>(Month) (Day) (Year)</small>		
DATE OF BIRTH <u>Apr 11</u> , 18 <u>52</u> <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from <u>Jan 3rd</u> , 191 <u>2</u> , to <u>Jan 16th</u> , 191 <u>2</u> , that I last saw her alive on <u>Jan 16th</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>10</u> am. The CAUSE OF DEATH* was as follows: <u>Pneumonia Fever</u>		
AGE <u>59</u> yrs. <u>8</u> mos. <u>4</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?	<u>97</u> 108 (Duration) <u>9</u> yrs. <u>13</u> mos. <u>13</u> ds. Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>W. J. Cabeman</u> M. D. <u>1-17th 1912</u> (Address) <u>Forestland</u>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-0</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>			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? _____		
PARENTS	NAME OF FATHER <u>John Pickering</u>		Former or usual residence _____		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Texas</u>		PLACE OF BURIAL OR REMOVAL <u>Salem Park Co</u>		
	MAIDEN NAME OF MOTHER <u>Rebekah Thompson</u>		DATE OF BURIAL <u>Jan 19</u> , 191 <u>2</u>		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Texas</u>		ADDRESS <u>Forestland</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>G. M. Jones</u>			UNDERTAKER <u>W. H. Field</u>		
(ADDRESS) <u>Chiquot, Mo</u>			REGISTRAR <u>W. H. Field</u>		
Filed <u>Jan 17</u> , 191 <u>2</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*, *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.)



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

PLACE OF DEATH

County Wheeler
Township E. Burton
or Fordland
Village Fordland
or
City _____ (NO _____ St. _____ Ward) _____

Registration District No. 898 File No. 3945
Primary Registration District No. 6703 Registered No. 2

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

FULL NAME Reberah Jane Jones

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH 1-17- 1912
(Month) (Day) (Year)

DATE OF BIRTH 4-11- 1857
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1912, to 1-16, 1912,
that I last saw her alive on " ", 1912,
and that death occurred, on the date stated above, at 60 m.

AGE 59 yrs. 8 mos. 4 ds.
If LESS than 1 day, ____ hrs. or ____ min.

The CAUSE OF DEATH* was as follows:

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

X P. Colan
Pneumonia
(Duration) _____ yrs. _____ mos. 13 ds.

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

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. J. Railway M. D.
1-17 1912 (Address) Fordland

NAME OF FATHER John R. Jones

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

MAIDEN NAME OF MOTHER Rebecca Thompson

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

*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. _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. M. Jones

(ADDRESS) Belmont, Mo.

PLACE OF BURIAL OR REMOVAL Salem Park Co. DATE OF BURIAL 1-19 1912

Filed Jan 17 1912 W. J. Railway REGISTRAR

UNDERTAKER Mayfield Fordland ADDRESS _____

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.

WHEELER COUNTY, WITH CONTINUING INK—THIS IS A PERMANENT RECORD

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

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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.)