

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.

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

PLACE OF DEATH
 County Laclede ✓
 Township Mayfield Registration District No. 277 File No. 5744
 or Village _____ Primary Registration District No. 5610 Registered No. 3
 or City _____ (NO. _____) St. _____ Ward _____

 FULL NAME Mary Hester Jordan

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

8 (Month) 23 (Day) 1855 (Year)

AGE

56 yrs. 5 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Housekeeping(b) General nature of industry, business, or establishment in which employed (or employer) 9-0

BIRTHPLACE

(City or town, State or foreign country) Ill.

PARENTS

NAME OF FATHER

William McKee

BIRTHPLACE OF FATHER

Ill.

MAIDEN NAME OF MOTHER

Rebecca Cleby

BIRTHPLACE OF MOTHER

Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T Jordan(ADDRESS) Stoutland MoFiled July 10 1912 6 E Carline REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

1 (Month) 26 (Day) 1912 (Year)

 I HEREBY CERTIFY, that I attended deceased from Jan 23, 1912, to Jan 26, 1912, that I last saw her alive on Jan 25, 1912, and that death occurred, on the date stated above, at 7 pm.

The CAUSE OF DEATH* was as follows:

Paralysis
82 D
97 (Duration) ___ yrs. ___ mos. 3 ds.

Contributory

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

(Signed)

W P Adams M. D.
Jan 26 1912 (Address) Stoutland

*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 4 yrs. 5 mos. ___ ds. in the 42 yrs. ___ mos. ___ ds. State
Where was disease contracted if not at place of death? Place of death

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

Stoutland Cemetery 1 27 1912

DATE OF BURIAL

UNDERTAKER

John O Thompson Stoutland

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*, *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.)



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MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Laclede
Township Mayfield
or
Village _____
or
City _____ (NO _____ St. _____ Ward _____)

Registration District No. 277 File No. 5744
Primary Registration District No. 5610 Registered No. _____

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

FULL NAME Mary Hester Jordan

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH 8 28 1853
(Month) (Day) (Year)

AGE 56 yrs. 5 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.

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

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

PARENTS
NAME OF FATHER William McKee
BIRTHPLACE OF FATHER Ky
MAIDEN NAME OF MOTHER Rebecca Cleby
BIRTHPLACE OF MOTHER Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John G. Jordan
(ADDRESS) Stoutland Mo

Filed Feb 10 1919 J. E. Coarles REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1 26 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 23, 1912, to Jan 26, 1912, that I last saw her alive on Jan 25, 1912, and that death occurred, on the date stated above, at 7:40 AM.

The CAUSE OF DEATH* was as follows: of the blood vessels
Paralysis

(Duration) ___ yrs. ___ mos. 3 ds.

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

(Signed) W. C. Paal M. D.
Jan 26 1912 (Address) Stoutland

* 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 Stoutland Cem DATE OF BURIAL 1/27 1912

UNDERTAKER John A. Thompson ADDRESS Stoutland Mo

Revised United States Standard Certificate of Death

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

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