

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 Perry
 Township Cinquehomme Registration District No. 659 File No. 17844
 or
 Village _____ Primary Registration District No. 5876 Registered No. 7
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Francis Marie Janette

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE single
 MARRIED _____ WIDOWED _____
 OR DIVORCED _____ (If write the word)

DATE OF BIRTH Jan. 16, 1912
 (Month) (Day) (Year)

AGE _____ yrs. 4 mos. 6 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) _____

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

PARENTS
 NAME OF FATHER Marcellus Janette
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Perry Co. Mo.
 MAIDEN NAME OF MOTHER Mary Louise Siefert
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Perry Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Marcellus Janette
 (ADDRESS) Perryville Mo
 Filed May 22, 1912 G. B. Bowman
 REGISTRAR
Byrd Popp.

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 5 21, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 17, 1912, to May 21, 1912, that I last saw her alive on May 21, 1912, and that death occurred, on the date stated above, at 2:12 p. m.

The CAUSE OF DEATH* was as follows:
Pneumonia
107A

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Cold
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. M. Henderson M. D.
May 22, 1912 (Address) Perryville 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 Mt. Hope Cem. DATE OF BURIAL May 22, 1912
 UNDERTAKER Frank Zollner ADDRESS Perryville

PLACE OF DEATH

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

County _____
Township _____ Registration District No. _____ File No. _____
or _____
Village _____ Primary Registration District No. _____ Registered No. _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____, 191____ (Day) _____ (Year) _____
AGE	_____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) _____
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(ADDRESS) _____
Filed _____, 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (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 _____ m. The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ (Address) _____ M. D. _____ (Duration) _____ yrs. _____ mos. _____ ds.

*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. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Form _____ of usual residence.

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____
UNDERTAKER _____ ADDRESS _____

Information should be carefully supplied, and stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. not statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Perry Registration District No. 659 File No. 17844
 Township Cinque Hommes or _____ Primary Registration District No. 5876 Registered No. 7
 Village _____ or _____ City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Francis Marie Janette

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED S.
 (If wife the word)
 DATE OF BIRTH Jan 16, 1912
 (Month) (Day) (Year)
 AGE 4 yrs. 5 mos. 5 ds.
 if LESS than 1 day, _____ hrs. or _____ min.

DATE OF DEATH May 21, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from May 7, 1912, to May 21, 1912, that I last saw her alive on May 21, 1912, and that death occurred, on the date stated above, at 3:21 p.m.

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

The CAUSE OF DEATH* was as follows:
pneumonia (Bronchus) *
 (Duration) _____ yrs. 5 mos. 5 ds.

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

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

PARENTS NAME OF FATHER Marcellus Janette
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Perry Co. Mo.
 MAIDEN NAME OF MOTHER Mary Louise Siefert
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Perry Co. Mo.

Signed T. M. Hudson M. D. X
July 9, 1912 (Address) Perryville Mo.

*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) Marcellus Janette
 (ADDRESS) Perryville 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 July 9, 1912 C. P. Bowman REGISTRAR

PLACE OF BURIAL OR REMOVAL Old Hope Cem DATE OF BURIAL May 22, 1912
 UNDERTAKER Frank Zollner ADDRESS Perryville Mo.

Note: Every item of information should be stated EXACTLY. SEX, AGE should be stated EXACTLY. P.H.Y. CAUSE OF DEATH in death certificate should be classified. Exact statement of OCCUPATION.

SUPPLEMENTARY

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 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.)