

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			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	<u>Dunklin</u>	Registration District No.	<u>287</u>	File No. <u>325393</u>
Township	<u>Clay</u>	Primary Registration District No.	<u>5405</u>	Registered No. <u>56</u>
City		(NO. _____ St. _____ Ward _____)		
FULL NAME <u>Not named.</u>				
PERSONAL AND STATISTICAL PARTICULARS				
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)		
DATE OF BIRTH <u>Oct, 5, 1912</u> (Month) (Day) (Year)				
AGE		IF LESS than 1 day, <u>2</u> hrs. or <u>6</u> 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) <u>Dunklin Co Mo.</u>				
PARENTS	NAME OF FATHER <u>Jasper A. Adkins</u>			
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Lake Co, Tenn</u>			
	MAIDEN NAME OF MOTHER <u>Maudie Tinning</u>			
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Dunklin Co Mo</u>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>J. M. Adkins</u>				
(ADDRESS) <u>Hammersville Mo.</u>				
FILED <u>Oct, 12, 1912</u> <u>H. H. Lambaugh</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
DATE OF DEATH <u>Oct, 11, 1912</u> (Month) (Day) (Year)				
I HEREBY CERTIFY, that I attended deceased from <u>Oct 10, 1912</u> to <u>Oct 11, 1912</u> , that I last saw him alive on <u>Oct 11, 1912</u> , and that death occurred, on the date stated above, at <u>7:30 P.M.</u>				
The CAUSE OF DEATH* was as follows: <u>Convulsions</u>				
(Duration) <u>103</u> yrs. _____ mos. _____ ds.				
Contributory (SECONDARY) <u>None</u>				
(Signed) <u>H. H. Lambaugh</u> M. D. <u>Oct, 12, 1912</u> (Address) <u>Hammersville</u>				
*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>Hammersville Ky.</u>				DATE OF BURIAL <u>10/12, 1912</u>
UNDERTAKER <u>J. F. Kinsolving</u>				ADDRESS <u>Hammersville Mo</u>

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MISSOURI STATE BOARD OF HEALTH

PLACE OF DEATH
County Hunklin
Township Clay
Village _____
City _____ (NO. _____ St. _____ Ward _____)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 287 File No. 32539
Primary Registration District No. 5400 Registered No. 56

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

FULL NAME

Not named

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR DIVORCED ☐ (Write the word)

DATE OF BIRTH Oct. 5, 1912
(Month) (Day) (Year)

AGE 6 yrs. 0 mos. 0 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) Hunklin Co. Mo.

NAME OF FATHER Jasper A. Atkins

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

MAIDEN NAME OF MOTHER Margie Tinning

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Atkins

(ADDRESS) Hornersville Mo.

FILED 10/12/12 REGISTRAR G. H. Lamb

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 11, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 10, 1912 to Oct. 11, 1912, that I last saw her alive on Oct. 11, 1912, and that death occurred, on the date stated above, at 7:30 P.

The CAUSE OF DEATH* was as follows:

convulsions
Infantile

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

Contributory (SECONDARY)

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

Signed G. H. Lamb M. D. Oct. 12, 1912 (Address) Hornersville

*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 Hornersville Mo. DATE OF BURIAL 10-12-1912

UNDERTAKER F. F. Kinsding ADDRESS Hornersville

Original file, date 12/12/12 All information called for must be written on the Supplementary Certificate.

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*, *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.)

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

County Dunklin
 Township Clay
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 287 File No. 32539
 Primary Registration District No. 5405 Registered No. 56

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

FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. 6 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) _____

PARENTS

NAME OF FATHER Jasper A. Perkins

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 Oct 11, 1912
 (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 _____ m.

The CAUSE OF DEATH* was as follows:

Convulsions
Due to Congestion of
Stomach
 (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) J. H. Lumbough M. D.
4/3, 1913 (Address) Hannsville 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

DATE OF BURIAL

UNDERTAKER

ADDRESS

Revised United States Standard Certificate of Death

(Approved by U. S. Consus and American Public Health
Association)

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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.)