

WRITE PLAINLY IN 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 Stoddard
Township Coaston
or South Fork
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 837 File No. 35037
Primary Registration District No. 6099 Registered No. 84

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

FULL NAME Jesse Blocker

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH April 4, 1890
(Month) (Day) (Year)

AGE 22 yrs. 6 mos. ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1-02

BIRTHPLACE (City or town, State or foreign country) Pike Township Stoddard Co Mo

PARENTS
NAME OF FATHER Francis M. Blocker
BIRTHPLACE OF FATHER (City or town, State or foreign country) Cape Girardeau Co Mo
MAIDEN NAME OF MOTHER Susan Vaughn
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Stoddard Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Blocker
(ADDRESS) Avert 9 mo

Filed Oct 31, 1912 Jno Ashley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October 31, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 17, 1912, to October 31, 1912, that I last saw him alive on October 30, 1912, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:
Typhoid fever complicated with
dianthra caused by over eating
120 B (Duration) yrs. 1 mos. 14 ds.
Contributory dianthra as above
(SECONDARY) (Duration) yrs. ___ mos. 20 ds.

(Signed) Thos B. Turnbaugh M. D.
Oct 31, 1912 (Address) Bloomfield 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 North Chick DATE OF BURIAL 11/1, 1912

UNDERTAKER W. B. Sawyer ADDRESS Bloomfield Mo

WITH 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

County Stoddard
Township Castor
or
Village
or
City (NO. _____) (St. _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registration District No. 837 File No. 4
Primary Registration District No. 6099 Registered No. 84

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

FULL NAME Jesse Blocker

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m</u>	COLOR OR RACE <u>w.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>w.</u>
DATE OF BIRTH <u>April 26</u> , 19 <u>10</u> (Month) (Day) (Year)		
AGE <u>22</u> yrs. <u>6</u> mos. <u>2</u> ds. if LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Pike Tp. Stoddard Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Francis M. Blocker</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Capu Gir. Co. Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Susana Vaughn</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Stoddard Co. Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 31, 1912
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Sept 17, 1912, to Oct. 31, 1912, that I last saw him alive on " 30, 1912, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:
Typhoid fever, complicated with diarrhoea caused by over eating

(Duration) _____ yrs. 1 mos. 14 ds.

Contributory Diarrhoea as above
(SECONDARY) (Duration) _____ yrs. _____ mos. 20 ds.

(Signed) Thos. B. Turnbaugh M. D.
Oct. 31, 1912 (Address) Bloomfield 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) F. M. Blocker
(ADDRESS) Avert Mo.

Filed Dec 5 1912 J. W. Schley REGISTRAR

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>North Antioch</u>	DATE OF BURIAL <u>11/1</u> , 19 <u>12</u>
UNDERTAKER <u>W. A. Harper</u>	ADDRESS <u>Bloomfield Mo.</u>

Original file. date Oct 27, 1912 All information called for must be written on this 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*, *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.)

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