

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 Lafayette  
Township Clay  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 456 File No. 36437  
Primary Registration District No. 5622A Registered No. \_\_\_\_\_

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

FULL NAME Jessie Fay Colvin

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb 21, 1902  
(Month) (Day) (Year)

AGE 10 yrs, 8 mos, 10 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) House Work

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

PARENTS  
NAME OF FATHER Robt Colvin  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Va.  
MAIDEN NAME OF MOTHER Freda Fikes  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Colvin  
(ADDRESS) Odessa

Filed Nov 2, 1912 J. F. Gairnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Oct 20, 1912, to Oct 31, 1912, that I last saw her alive on Oct 31, 1912, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:  
Peritonitis, abscess  
115A

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (SECONDARY) (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. G. Mackey M. D.  
(Address) Odessa 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 Greenton DATE OF BURIAL 11/1, 1912  
UNDERTAKER C. E. Prather ADDRESS Odessa

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 \_\_\_\_\_

Township \_\_\_\_\_ or Village \_\_\_\_\_ or City \_\_\_\_\_

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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 \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (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) \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH, \_\_\_\_\_ (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 \_\_\_\_\_ in. The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

\_\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*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 \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_, \_\_\_\_\_ REGISTRAR

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

PLACE OF DEATH

County Lafayette  
Township Clay  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 456 File No. \_\_\_\_\_

Primary Registration District No. 5622A Registered No. \_\_\_\_\_

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

FULL NAME

Jennie Fay Calvin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

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

DATE OF BIRTH Feb 21, 1902  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 20, 1912, to Oct 31, 1912, that I last saw her alive on Oct 31, 1912, and that death occurred, on the date stated above, at 3a.m.

AGE 10 yrs. 8 mos. 10 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 none  
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

Peritonsillar abscess  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PARENTS NAME OF FATHER Robt Calvin BIRTHPLACE OF FATHER (City or town, State or foreign country) Va MAIDEN NAME OF MOTHER Georgia Fyles BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

(Signed) J. M. Mackey M. D. Oct 31, 1912 (Address) Adessa 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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Informant) J. W. Calvin

Where was disease contracted If not at place of death? \_\_\_\_\_ Former or usual residence \_\_\_\_\_

(ADDRESS) Adessa

PLACE OF BURIAL OR REMOVAL Greentown DATE OF BURIAL 11/1, 1912

Filed Nov 2nd 1912 E. F. Gaines REGISTRAR

UNDERTAKER C. E. Prather ADDRESS Adessa Mo

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

# 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 *septicæmia*," "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.)

50487

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

PLACE OF DEATH

County Lafayette  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. \_\_\_\_\_ File No. 36.437  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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

FULL NAME

Jessie Fay Calvin

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. \_\_\_\_\_ 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 \_\_\_\_\_  
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. 31, 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:

Structural Abscess

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D. \_\_\_\_\_ 191\_\_\_\_\_ (Address) \_\_\_\_\_

\*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 REGENT 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 \_\_\_\_\_, 191\_\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

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# Revised United States Standard Certificate of Death

[Approved by U. S. Census 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.)