

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 Jettis
 Township _____
 or
 Village _____
 or
 City Sedalia (NO. _____) St. _____ Ward _____
 Registration District No. 668 File No. 23743
 Primary Registration District No. 3037 Registered No. _____

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

FULL NAME Miss Gussie Jackson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Negro SINGLE MARRIED WIDOWED OR DIVORCED Married
 DATE OF BIRTH July 12 1891
 (Month) (Day) (Year)
 AGE 22 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
 (City or town, State or foreign country) Cooper Co

PARENTS
 NAME OF FATHER Samuel Malory
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Cooper
 MAIDEN NAME OF MOTHER Mary Harris
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Cooper Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Geo Jackson

(ADDRESS) 113 23 Grand

Filed July 14 1913 H. B. Long
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 17 1913, to July 12 1913,
 that I last saw her alive on July 12 1913,
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Peritonitis
 1913 (Duration) _____ yrs. _____ mos. 25 ds.

Contributory (SECONDARY)
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. M. Harris M. D.
July 16 1913 (Address) 116 N. Main St.

*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 Sedalia DATE OF BURIAL July 13 1913
 UNDERTAKER Wm. A. Sedalia 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, peritonacum*, 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 septichaemia," "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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RECORDING INFORMATION—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH Pettis
County Pettis
Township _____ or Village _____ or City Sedalia (NO. _____) (St. _____ Ward _____)
Registration District No. 668 File No. _____
Primary Registration District No. 3032 Registered No. 160
FULL NAME Mrs. Gussie Jackson (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>Black</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>Satisfactory Information Supplied</u>		DATE OF DEATH <u>July 12, 1913</u> (Month) (Day) (Year)
AGE <u>Satisfactory Information Supplied</u>		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 _____.
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Satisfactory Information Supplied</u>		The CAUSE OF DEATH* was as follows: <u>Peritonitis of diaphragm is cause given by physician J. M. Harris (Record)</u>
BIRTHPLACE (City or town, State or foreign country) <u>Satisfactory Information Supplied</u>		(Duration) _____ yrs. _____ mos. <u>25</u> ds.
PARENTS	NAME OF FATHER	Contributory (SECONDARY) Duration _____ yrs. _____ mos. _____ ds.
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	(Signed) <u>J. M. Harris</u> M. D. <u>July 13, 1913</u> (Address) <u>116 W. Main St.</u>
	MAIDEN NAME OF MOTHER	* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	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 _____

SUPPLEMENTARY INFORMATION SUPPLIED

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Satisfactory Information Supplied
(ADDRESS) _____
Filed July 14, 1913 J. B. Long REGISTRAR

PLACE OF BURIAL OR REMOVAL Satisfactory Information Supplied
DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS Supplied

Revised United States Standard Certificate of Death

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

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