

PLACE OF DEATH

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

County Livingston

Township _____

Village _____

City Chillicothe (NO. St Marys Hospital St. _____ Ward _____)

Registration District No. 508

File No. 5351

Primary Registration District No. 8026

Registered No. 28

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

FULL NAME Miss Oldreath Jacobs 4 days at Hospital

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb. 23, 1914
(Month) (Day) (Year)

DATE OF BIRTH Sept. 15, 1894
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 19, 1914, to Feb. 23, 1914, that I last saw her alive on Feb. 23, 1914, and that death occurred, on the date stated above, at 4:29 m.

AGE 19 yrs. 5 mos. 18 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 House work
(b) General nature of industry, business, or establishment in which employed (or employer) keeping house

358 Pelvic Peritonitis
139B
179

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

(Duration) ___ yrs. ___ mos. 6 ds.

NAME OF FATHER Geo. Jacobs

Contributory Pelvic abscess
(SECONDARY) (Duration) ___ yrs. ___ mos. 2 ds.

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

(Signed) H.M. Zweep + J.W. Murray
Feb. 23, 1914 (Address) Chillicothe - Mo.

MAIDEN NAME OF MOTHER Nancy Cambron

*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) Indiana

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death ___ yrs. ___ mos. 4 ds. In the ___ yrs. ___ mos. ___ ds.

(Informant) Ludlow Mo

Where was disease contracted if not at place of death? At Home

(ADDRESS) 418 J. Jacobs

Farmer or usual residence Ludlow Mo

Filed 2-23-14 J.C. Shuttles

PLACE OF BURIAL OR REMOVAL Mt Olive Cemetery DATE OF BURIAL Feb. 25, 1914

REGISTRAR

UNDERTAKER Geo. H. Perryman ADDRESS Chillicothe 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.

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.)

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

County

Livingston

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

Township

or

Village

or

City

Chillicothe

Registration District No.

508

File No.

Primary Registration District No.

3026

Registered No.

FULL NAME

Miss Goldreuth Jacobs.

[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 *F* COLOR OR RACE *W* SINGLE MARRIED, WIDOWED OR DIVORCED *Single*

DATE OF DEATH *Feb. 23, 1914*

DATE OF BIRTH *Satisfactory Information Supplied.*

I HEREBY CERTIFY, that I attended deceased from *Satisfactory Information Supplied.*

AGE *Satisfactory Information Supplied.*

and that death occurred, on the date stated above, at *Satisfactory Information Supplied.*

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

The CAUSE OF DEATH* was as follows: *Pelvic Peritonitis*

BIRTHPLACE (City or town, State or foreign country)

Contributory *Pelvic abscess*

PARENTS NAME OF FATHER BIRTHPLACE OF FATHER MAIDEN NAME OF MOTHER BIRTHPLACE OF MOTHER

(Duration) *93* yrs. *93* mos. *93* ds. (Signed) *H. M. Swore* M. D. *2-23-14* (Address) *Chillicothe, Mo.*

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

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

(ADDRESS)

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death *93* yrs. *93* mos. *93* ds. In the *93* yrs. *93* mos. *93* ds. State *93* yrs. *93* mos. *93* ds.

Filed *3-26-14* 1914 *J. C. Schultz* REGISTRAR

Where was disease contracted If not at place of death? Former or usual residence. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL *Satisfactory Information Supplied.* ADDRESS *Satisfactory Information Supplied.*

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