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

PLACE OF DEATH

County Pulaski

Township Liberty

or Village

or City Richland (NO. ____ St.: ____ Ward)

Registration District No. 712

Primary Registration District No. 4427

File No. 5762

Registered No. 4

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

FULL NAME John Clifton Jeffries

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov. (Month) 6 (Day), 1913 (Year) (1913)

AGE ____ yrs. 2 mos. 27 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS

NAME OF FATHER John Clayton Jeffries

BIRTHPLACE OF FATHER (City or town, State or foreign country) Camden Co Mo

MAIDEN NAME OF MOTHER Sarah Elizabeth Degrassen

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Clayton Jeffries

(ADDRESS) Richland Mo

Filed Feb 3, 1914. Everett A. Oliver. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feby (Month) 3rd (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feby 3, 1914, to Feby 3, 1914, that I last saw him alive on Feby 3, 1914, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Convulsions (only lived 1/2 hour after I first saw him)

(Duration) — yrs. — mos. 1 ds.

Contributory (SECONDARY) Unknown

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H C Murphey M. D.

Feb 3, 1914 (Address) Richland 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 Anglaize Cemetery Camden Co. Mo

DATE OF BURIAL Feb 4, 1914

UNDERTAKER None

ADDRESS

St[illegible] 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 *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.)

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

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

PLACE OF DEATH

County: Pulaski

Township: ____

Registration District No.: 712 File No.: ____

Village or City: Richland (No. ____ St. ____ Ward ____)

Primary Registration District No.: 4427 Registered No.: 4

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

FULL NAME John Clifton Jeffries

PERSONAL AND STATISTICAL PARTICULARS

SEX: M COLOR OR RACE: W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: ____ (Month) ____ (Day) ____ (Year)

Satisfactory Information Supplied.

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 April 10/9/14 191 Everett A. Oliver X REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb. -3- 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw him alive on ____, 191__, and that death occurred, on the date stated above, at ____ m.

Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:

Convulsions (only lived ½ hour after I first saw him) Tuberculosis Meningitis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Unknown Tuberculosis

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. C. Wheelchart M.D.

2-3, 191 4 (Address) Richland 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: ____, 191__

UNDERTAKER: ____ ADDRESS: ____

Original file, date ____, 19__ All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

Satisfactory Information Supplied.

CAUSE OF DEATH in plain ... so that it may be properly classified. Exact ... should be stated ... carefully supplied ... PHYSICIAN'S OCCUPATION is ... important.

Revised United States Standard Certificate of Death

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

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