

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

PLACE OF DEATH

County Pettis

Township \_\_\_\_\_

Village \_\_\_\_\_

City Sedalia

Registration District No. 668

File No. 36294

Primary Registration District No. 3032

Registered No. 273

(NO. North - West - East - South - By Highway - St. - 3 - Ward)

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

FULL NAME James Jenkins

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)

DATE OF DEATH Nov. 14, 1914  
(Month) (Day) (Year)

DATE OF BIRTH January 28<sup>th</sup>, 1861  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 14, 1914, to Nov. 14, 1914, that I last saw him alive on Nov. 14, 1914, and that death occurred, on the date stated above, at 5:30 p.m.

AGE 53 yrs 9 mos 17 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Cerebral Hemorrhage  
4 hours  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

OCCUPATION (a) Trade, profession, or particular kind of work mechanic  
(b) General nature of industry, business, or establishment in which employed (or employer) at M. K. & T. round-house.

BIRTHPLACE (City or town, State or foreign country) Pettis Co., Missouri

NAME OF FATHER James J. Jenkins

BIRTHPLACE OF FATHER (City or town, State or foreign country) Pettis Co., Missouri

MAIDEN NAME OF MOTHER Susan V. Kelly

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

Contributory (Second) \_\_\_\_\_  
(Signed) Geo. Ed. Crest M. D.  
11-14, 1914 (Address) Sedalia Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Jenkins  
6421 Nashville Ave  
(ADDRESS) St. Louis, 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 55 yrs. \_\_\_ mos. \_\_\_ ds. In the 3 yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted Sedalia Mo  
If not at place of death?  
Former or usual residence Sedalia Mo

Filed 7/10/14, 1914 J. D. Mitchell  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Centerview Mo DATE OF BURIAL Nov 15, 1914  
UNDERTAKER M. Augustin Br ADDRESS Sedalia 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) *Colton 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.)

Mr. George McNeil

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County

Township

Village

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

(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

MEDICAL CERTIFICATE OF DEATH

SEX *M*

COLOR OF RACE *W*

SINGLE *M*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF DEATH

*Nov 14* 191*4*  
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

if LESS than  
1 day, hrs  
or min

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 *St. P.*

OCCUPATION

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

CAUSE OF DEATH\* was as follows:

*Orchid pneumonia probably rupture of blood vessel*

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)

PARENTS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191

REGISTRAR

Contributory

(Signed)

1914

(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 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

UNDERTAKER

ADDRESS

Original file, date

1914

19

Supplementary Certificate

# Revised United States Standard Certificate of Death

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