

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 Cedar
 Township Bof or _____
 Village _____ or _____
 City _____ (NO. _____) St.: _____ Ward _____

Registration District No. 103 File No. 445
 Primary Registration District No. 5225 Registered No. 3

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

FULL NAME Mary M Jeffery

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF BIRTH Dec 25, 1887
(Month) (Day) (Year)

AGE 87 yrs. 4 mos. 17 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) _____

DATE OF DEATH Jan 12, 1934
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to Nov 30, 1934
 that I last saw her alive on Nov 30, 1934
 and that death occurred, on the date stated above, at 4 P m.
 The CAUSE OF DEATH* was as follows:
45 D cancer
100 R
45
 (Duration) ___ yrs. ___ mos. ___ ds.

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

PARENTS
 NAME OF FATHER James Jackson
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee
 MAIDEN NAME OF MOTHER Susan Hunter
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

Contributory Branchitis
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) Russell B. Mair M. D.
Jan 12, 1934 (Address) Dillon mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Joe Jeffery
 (ADDRESS) El Trade Bldg
Mo.
 Filed 1 18, 1935 W. Dawson
 REGISTRAR

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 Grand Ridge Cem DATE OF BURIAL Jan 13, 1934
 UNDERTAKER W. S. Sider ADDRESS Edwards spgs

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, 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), 20 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "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.)

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

PLACE OF DEATH

County

Cedar Box

Township

Village

City

Registration District No.

163

File No.

Primary Registration District No.

5228

Registered No.

3

(NO.)

St.

Ward

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

FULL NAME

Mary M Jeffery

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

F

COLOR OR RACE

W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

widow

DATE OF DEATH

June 12, 1915
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.

HEREBY CERTIFY, that I attended deceased from Satisfactory information supplied.

that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cancer on Inferior Maxillary

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

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

Contributory (SECONDARY)

W. Bronchitis
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R B Mary M. D.
Jun 15, 1915 (Address) *Filley*

*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 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

STATE OF BURIAL

UNDERTAKER

ADDRESS

W H Siders

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

1/18 191*5* *S. W. Dawson*

REGISTRAR

Original file, date *JAN 1915*

All information called for must be written on this Supplementary Certificate.

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.

SUPPLEMENTARY
Satisfactory Information Supplied

Information Supplied

Revised United States Standard Certificate of Death

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

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