

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34996

1 PLACE OF DEATH

County *Missouri*
Township *Madison*
or
Village
or
City

Registration District No. *553* File No.
Primary Registration District No. *5748* Registered No.
St. Ward

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

2 FULL NAME

Elizabeth Jumper

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)

16 DATE OF DEATH *Dec 9*, 1915
(Month) (Day) (Year)

DATE OF BIRTH *Dec 4*, 1835
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Dec 7*, 1915, to *Dec 9*, 1915, that I last saw *her* alive on *Dec 7*, 1915,

AGE *80* yrs. — mos. *5* ds. If LESS than 1 day, hrs. or min.?

and that death occurred, on the date stated above, at *11 A.* m.

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

The CAUSE OF DEATH* was as follows:

Paralysis due to cerebral hemorrhage

BIRTHPLACE *Indiana*
City or town, State or foreign country

(Duration) yrs. mos. ds.

10 NAME OF FATHER *Nicholas Jumper*

CONTRIBUTORY (Secondary) *Pneumonia*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ind. / know*

(Duration) yrs. mos. ds.

12 MAIDEN NAME OF MOTHER *Clidamy Hinchaw*

(Signed) *Chas. W. Jumper* M. D.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ind. / know*

Dec 9, 1915 (Address) *Princeton Mo*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) *Mrs. Jane Ballard*
(Address) *Princeton Mo*

18 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

15 Filed *Oct 19 1915* *A. G. Bell* Registrar

19 PLACE OF BURIAL OR REMOVAL *Goodwill Cem.* DATE OF BURIAL *Dec 11*, 1915

20 UNDERTAKER *H. H. Buss* ADDRESS *Mo. Moring*

N. B.—Every item of information should be given in full. CAUSE OF DEATH

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), *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.)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state if informant is a physician. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH
 County Merces
 Township Madison
 or
 Village
 or
 City

Registration District No. 555 File No.
 Primary Registration District No. 5748 Registered No.
 (NO. St. Ward)

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

2 FULL NAME Elizabeth Younkin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX F 4 COLOR OF RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED M.
 (Write the word)
 6 DATE OF BIRTH
 (Month) (Day) (Year)
 7 AGE
 yrs. mos. ds. IF LESS than 1 day, hrs. or min.?
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer) when deceased
 9 BIRTHPLACE
 (City or town, State or foreign country)

16 DATE OF DEATH Dec. 9 1915
 (Month) (Day) (Year)
 17 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.
 The CAUSE OF DEATH* was as follows:

Paralysis due to cerebral intercranial hemorrhage.

CONTRIBUTORY Bunch's Pneumonia
 (Secondary) (Duration) yrs. mos. ds. 2
 (Signed) J. R. Bowen M. D.
12/9 1915 (Address) Princeton, Wis.

SUPPLEMENTARY

10 NAME OF FATHER
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

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

18 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

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

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL _____ 191____

15 Filed Dec 18 1915 J. R. Beal
 Registrar

20 UNDERTAKER ADDRESS

Original file, date OCT - 1915

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

Revised United States Standard Certificate of Death

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

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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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthénia," "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.)