

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

38186

1 PLACE OF DEATH

County *Marion*

Township

Village

City *Hannibal*

Registration District No. *547*

File No.

Primary Registration District No. *3079*

Registered No. *306*

(NO. *919 Broadway*, St. *3* Ward)

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

2 FULL NAME *Alberta Viola Jones*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Infant*

6 DATE OF BIRTH *Oct 31* 19*16*

7 AGE *20* yrs. *20* mos. *20* ds. If LESS than 1 day, *0* hrs. or *0* min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *Missouri*

PARENTS 10 NAME OF FATHER *Amel Jones* 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Iowa* 12 MAIDEN NAME OF MOTHER *Oltha Albett* 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Missouri*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *A. H. Patrick* (Address) *919 Broadway*

15 Filed *Nov 21*, 191*6* *R. A. Spencer* Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov 20*, 191*6*

17 I HEREBY CERTIFY, that I attended deceased from *Nov. 19*, 191*6*, to *Nov. 20*, 191*6*, that I last saw her alive on *Nov. 20*, 191*6*, and that death occurred, on the date stated above, at *2:50* p.m.

The CAUSE OF DEATH* was as follows: *meningitis*

70 Cause not known (Duration) *2* yrs. *2* mos. *2* ds.

CONTRIBUTORY *Hematemesis* (Secondary) (Duration) *1* yrs. *1* mos. *1* ds.

(Signed) *R. Schmidt* M. D. *11-21*, 191*6* (Address) *Hannibal, Mo.*

*State the Disease Causing Death, or, in death 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 *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds. Where was disease contracted if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *St. Christ Cemetery* DATE OF BURIAL *Nov 21*, 191*6*

20 UNDERTAKER *Seivers & Schwartz* ADDRESS *Hannibal*

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*, *Composer*, *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 "Asthemia," "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

1 PLACE OF DEATH

County Monroe

Township _____

or _____

Village _____

or _____

City Nauvoo

Registration District No. 547

File No. _____

Primary Registration District No. 3029

Registered No. 306

(No. 919 Broadway St. 3 Ward)

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

2 FULL NAME

Alberta Viola Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED Wid
(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) _____

9 BIRTHPLACE (City or town, State or foreign country) _____

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) _____

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

15 Filed 11/31 1916 RA Spencer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 30 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended, deceased from _____ 1916 to _____ 1916, that I last saw him alive on _____ 1916, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Meningitis
Cause not known
61 (Duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTOR (Secondary) Acute meningitis
(Signed) A. Schmidt M. D. (Duration) _____ yrs. _____ mos. 1 ds.
11/31 1916 (Address) _____

*State the Disease Causing Death, or, in death 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 _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1916

20 UNDERTAKER _____ ADDRESS _____

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.)

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