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

8119

PLACE OF DEATH

County Cape Girardeau Co ✓

Township Shawnee

or

Village

or

City (NO. , St.; Ward)

Registration District No. 129 File No.

Primary Registration District No. 6280 Registered No. 7

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

FULL NAME Jennie Virginia Abernathy

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F.	W	married

DATE OF BIRTH: March (Month) 14 (Day) 1918 (Year)

AGE: 60 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Cape Girardeau Co Mo

PARENTS

NAME OF FATHER: Peter Hughes

BIRTHPLACE OF FATHER (City or town, State or foreign country): North Carolina

MAIDEN NAME OF MOTHER: Linnie Sawyer

BIRTHPLACE OF MOTHER (City or town, State or foreign country): North Carolina

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Templeton

(ADDRESS) Friendly Ave. Mo.

Filed 3-25, 1918. P D Blaylock REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March (Month) 14 (Day) 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from 191 to 191, that I last saw h[er] alive on March 14, 1918, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion ✓

94 P

102

about 1½ hours (Duration)

Contributory Heart Failure (Secondary) (Duration) yrs. mos. ds.

(Signed) John W Hall M. D.

Buck. 14 1918 (Address) Homeland 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: Indian Creek Cem

DATE OF BURIAL: 3-25, 1918

UNDERTAKER: Dame & Rice

ADDRESS: Jackson R. 1

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 *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.)

HUGH STEPHENS, JEFFERSON CITY.

1 PLACE OF DEATH

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

County: Cape Girardeau

Township: Shawnee — Registration District No. 129 — File No. ....

or Village .... — Primary Registration District No. 5180 — Registered No. 7

or City .... (NO. ...., ... St.; .... Ward)

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

2 FULL NAME: Tennessee Virginia Abernathy

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: F — 4 COLOR OR RACE: W — 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married	16 DATE OF DEATH: Mch 24, 1918 (Month) (Day) (Year)
6 DATE OF BIRTH: .... (Month) .... (Day), 1..... (Year)	17 I HEREBY CERTIFY, that I attended deceased from ...., 191....., to ...., 191....., that I last saw h..... alive on ...., 191....., and that death occurred, on the date stated above, at .... m.
7 AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?	The CAUSE OF DEATH* was as follows: Acute indigestion / Angina Pectoris (Duration) ..... yrs. ..... mos. ..... ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work .... (b) General nature of industry business, or establishment in which employed (or employer)	CONTRIBUTORY (Secondary): Heart failure (Duration) ..... yrs. ..... mos. ..... ds.
9 BIRTHPLACE (City or town, State or foreign country)	(Signed) John W Hall M. D. March 24, 1918 (Address) Fruitland Mo
PARENTS: 10 NAME OF FATHER	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
12 MAIDEN NAME OF MOTHER	At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Where was disease contracted if not at place of death? ....
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) .... (Address)	Former or usual residence ....
15	19 PLACE OF BURIAL OR REMOVAL .... DATE OF BURIAL ...., 191.....
Filed 3/25, 1918 R D Blaylock, Registrar	20 UNDERTAKER .... ADDRESS ....

Original file, date ...., 19.....

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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