

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

1 PLACE OF DEATH
County Livingston
Township Medicine
or
Village
or
City (NO. St.; Ward)

Registration District No. 309 File No. 8 9697
Primary Registration District No. 3678 Registered No. 8

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

2 FULL NAME Rosa Jacobs

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3 SEX male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

16 DATE OF DEATH Mar 21 1918
(Month) (Day) (Year)

6 DATE OF BIRTH September 15 1890
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 8 1918 to Mar 21 1918

7 AGE 17 yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?

that I last saw him alive on Mar 21 1918 and that death occurred, on the date stated above, at 12:30 p.m.

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer 44
(b) General nature of industry business, or establishment in which employed (or employer) 73 1/2

The CAUSE OF DEATH* was as follows:
Meningitis following
German Measles

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

(Duration) ... yrs. ... mos. 13 ds.

10 NAME OF FATHER Pete Jacobs

CONTRIBUTORY (Secondary) 8 (Duration) ... yrs. ... mos. ... ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri

(Signed) J. H. Messinger M. D.
Mar 23 1918 Address Wheeling Mo

12 MAIDEN NAME OF MOTHER Pearl Bobbery

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death 17 yrs. 6 mos. 4 ds. In the State 17 yrs. 6 mos. 4 ds.

(Informant) Peter Jacobs

Where was disease contracted if not at place of death? at place death

(Address) Chula Mo. R.

Former or usual residence. ✓

15 Filed 3-23 1918 O. Boyles Registrar

19 PLACE OF BURIAL OR REMOVAL Ricket Cemetery DATE OF BURIAL Mar 22, 1918

20 UNDERTAKER W. B. Scott ADDRESS Chula Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

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, 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 FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

County Linn Registration District No. 509 File No. _____
 or _____
 Township Medieval Primary Registration District No. 5078 Registered No. 8
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

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

2 FULL NAME Jura Jacobs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED W
 (Write the word)
 6 DATE OF BIRTH Sept 15 1900
 (Month) (Day) (Year)
 7 AGE 17 yrs. 6 mos. 16 ds. If LESS than 1 day... hrs. or... min.?
 8 OCCUPATION (a) Trade, profession, or particular kind of work Factory
 (b) General nature of industry business, or establishment in which employed or employer Harmonia Supplied
 9 BIRTHPLACE Livery Co. Mo.
 (City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 21 1918
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 18 1918 to March 21 1918
 that I last saw him alive on March 21 1918
 and that death occurred, on the date stated above, at 9:15 p.m.

18 CAUSE OF DEATH was as follows:
Meningitis following
Mr. Measles
 (Duration) 6 yrs. 8 mos. 8 ds.

CONTRIBUTORY Spinal meningitis
 (Secondary) (Duration) 18 yrs. 18 mos. 18 ds.
 Signed M.A. Musgrave M.D.
May 10 1918 (Address) Wheeling Mo.

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

20 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death 4 yrs. 6 mos. 18 ds. In the State 4 yrs. 6 mos. 18 ds.
 Where was disease contracted if not at place of death? At place of death
 Former or usual residence Wheeling Mo.

21 PLACE OF BURIAL OR REMOVAL Wheeler cemetery DATE OF BURIAL March 23 1918
 22 UNDERTAKER M.E. Booth ADDRESS Chula Mo.

PARENTS
 10 NAME OF FATHER Deto Jacobs
 11 BIRTHPLACE OF FATHER Missouri
 (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER Elizabeth
 13 BIRTHPLACE OF MOTHER Missouri
 (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Deto Jacobs
 (Address) Chula Mo. Route

15 FILED March 19 1918 Registrar O. Boyles

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 "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.)