

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

PLACE OF DEATH
County Nodaway
Township _____ or Village _____ or City Maryville (NO. _____ St. _____ Ward _____)
Registration District No. 625 File No. 20004
Primary Registration District No. 3031 Registered No. 52
FULL NAME Frederick W. Jacobs
(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
DATE OF BIRTH April 19, 1849
(Month) (Day) (Year)
AGE 71 yrs. 1 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION
(a) Trade, profession, or particular kind of work Lather
(b) General nature of industry, business, or establishment in which employed (or employer) _____
BIRTHPLACE
(City or town, State or foreign country) Illinois
PARENTS
NAME OF FATHER Ruben H. Jacobs
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Matilda F. Emery
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 28, 1920
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from May 27, 1920, to May 28, 1920, that I last saw him alive on May 27, 1920, and that death occurred, on the date stated above, at 7:30 m.
The CAUSE OF DEATH* was as follows:
Hemiplegia of left side
820
60
Contributory _____
(SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. H. Todd M. D.
5-30-20 (Address) Maryville, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth S. Byers
(ADDRESS) Shelbina, Mo.
Filed 5-30-20 R. Anthony REGISTRAR

PLACE OF BURIAL OR REMOVAL Miriam Cemetery DATE OF BURIAL May 30, 1920
UNDERTAKER Price Furn. Co. ADDRESS Maryville, Mo.

WRITE PLAINLY WITH BLUE INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated. OCCUPATION should be stated. If it may be properly classified. Exact statement of OCCUPATION is very important.

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*, *Sar-*

coma, 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.)



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

2004
~~20005~~

PLACE OF DEATH
City Madaway Registration District No. 625 File No. 20005
County Marionville Primary Registration District No. 3031 Registered No. 52
NAME Fredrick T. Jacobs St. _____ Ward _____
Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
MARRIED, WIDOWED, OR DIVORCED (write the word)
BAND OF WIFE OF _____
DATE OF BIRTH (MONTH, DAY AND YEAR) 71 Apr 19, 1849
YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION OF DECEASED father
Trade, profession, or usual kind of work
General nature of industry, business, or establishment in which employed (or employer)
Name of employer
PLACE (CITY OR TOWN) AND STATE OR COUNTRY Illinois
NAME OF FATHER Rubin T. Jacobs
BIRTHPLACE OF FATHER (CITY OR TOWN) AND STATE OR COUNTRY Ohio
MIDEN NAME OF MOTHER Matilda F. Emery
BIRTHPLACE OF MOTHER (CITY OR TOWN) AND STATE OR COUNTRY Ohio
Elizabeth & Byers
Shilbina Ind
5-30-19-20 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28 1920
17. I HEREBY CERTIFY, That I attended deceased from May 27, 1920, to May 28, 1920 that I last saw him alive on May 27, 1920, and that death occurred, on the date stated above, at 7:30 p. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemiplegia of left side
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J. J. Todd, M. D.
_____, 13 (Address) Marionville Mo
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Marion Cemetery DATE OF BURIAL May 30 1920
20. UNDERTAKER Price Fun Co ADDRESS Marionville Mo

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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.; *Branchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.