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

1713

1. PLACE OF DEATH

County Lawrence Registration District No. 4750 File No. 4

Township Spring River Primary Registration District No. 31639 Registered No. 2

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Jacob J. Saffer

(a) Residence. No. 40 years St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: 49 YEARS | MONTHS: 3 | DAYS: 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Philadelphia
(STATE OR COUNTRY) Penn

PARENTS

10. NAME OF FATHER John Saffer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Anna Margaret Meerx
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Agnes Saffer
(Address) Verona Mo

15. FILED Jan 24 1923 J Will Smith REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20, 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to Jan 20, 1923 that I last saw him alive on Jan 20, 1923, and that death occurred, on the date stated above, at 10:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

11 A

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) Influenza

(duration) ..... yrs. ..... mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J Will Smith, M.D

1/21/1923 (Address) Verona, 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: Colony Cem. Verona Mo
DATE OF BURIAL: 1/22/1923

20. UNDERTAKER: W R Wicks
ADDRESS: Verona Mo

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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *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," "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.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

1 PLACE OF DEATH

County Lawrence

Township or Village or City Spring River

475
3639

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of

Registered No.

(No. , St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jacob J. Saffer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X

6 DATE OF BIRTH , 1 (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 Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed Jan 21, 1945 J. Neil Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 20, 1973 (Month) (Day) (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.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) , M. D.

, 191 (Address)

* 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

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL , 191

20 UNDERTAKER

ADDRESS

11—3184

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