

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

1546^A

1. PLACE OF DEATH

County Lapeyette
Township Bates Co.
City no.

Registration District No. 436
Primary Registration District No. 0622

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Robert L. Jennings

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. - mos. - ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Edna Vance Jennings

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

Mar. 27/1869

7. AGE

YEARS 54

MONTHS

10

DAYS

3

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Blacksmith

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Wyersville

(STATE OR COUNTRY)

10. NAME OF FATHER

John D Jennings

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Wyersville

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Fannie Counts

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Wyersville

(STATE OR COUNTRY)

14.

INFORMANT
(Address)

Thos Vance
Wyersville

15.

Filed _____ 19 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov 30 1924

19 24

17.

I HEREBY CERTIFY, That I attended deceased from _____ ready _____ 17 _____ 1924, to _____ 30 _____ 1924 that I last saw him _____ alive on _____ 1924 and that death occurred, on the date stated above, at _____ Batesville, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

at home

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) David R. Gray, M. D.
, 19 _____ (Address) Bates City

*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

Obsequy Cem.

DATE OF BURIAL

2/1 1924

20. UNDERTAKER

L. G. Husman

ADDRESS

Wyersville

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

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 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," "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.

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

1. PLACE OF DEATH

County Lafayette
Township Bates City
City Bates City (No.) St. Ward)

Registration District No. 456
Primary Registration District No. 5622

File No.
Registered No.

2. FULL NAME

(a) Residence No. Robert J. Jennings St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX M 4. COLOR OR RACE W 5- SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 27 - 1867

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-----------|-----------|----------|--------------------------------------------|
| | <u>54</u> | <u>10</u> | <u>3</u> | |

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

9. BIRTHPLACE (CITY OR TOWN) Higginsville
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER John W. Jennings

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Higginsville
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Bornie Coats

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Higginsville
(STATE OR COUNTRY) Mo.

14. INFORMANT Thos. Vance
(Address) Odessa Mo.

15. FILED April 14 1924 BY R. Griffith M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30 1924

17. I HEREBY CERTIFY that I attended deceased from Jan 27, 1924, to Jan 27, 1924 that I last saw him alive on Jan 30, 1924, and that death occurred, on the date stated above, at 9:10 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Pneumonia
Acute Pneumonia

CONTRIBUTORY (SECONDARY) 1924
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH, DATE OF Jan 30 24

DID AN OPERATION PRECEDE DEATH? no. DATE OF Jan 30 24

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Signed David R. Griffith, M.D.
, 19 (Address) Bates City

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL Odessa Cem DATE OF BURIAL Feb 1 19 24

20. UNDERTAKER J. C. Kusman ADDRESS Odessa Mo.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

5
9
15
16
5