

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

Do not use this space.

17995

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 2407
 Township Raw Registration District No. 102 Registered No. 2407
 City Keosauqua City (Ne. Heatley Frontier) St. _____ Ward _____

2. FULL NAME

Lillie Jenison
 (a) Residence. No. 1715 Madison St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 9, 1887

7. AGE YEARS MONTHS DAYS If LESS than day, _____ hrs. or _____ min.
36 | 10 | 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Texas
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Moses Ink

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Fannie Galloway

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

14. INFORMANT Ira Jenison
 (Address) 1715 Madison

15. FILED 6/30, 1924 M. M. Lerowe REGISTRAR
Dy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 27 1924

17. I HEREBY CERTIFY, That I attended deceased from June 26th 1924 to June 27th 1924 that I last saw her alive on June 27th and that death occurred, on the date stated above, at 4:25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis following rupture of Pyl-Salpinx
13 1/2 (duration) yrs. mos. 7 da.

CONTRIBUTORY (SECONDARY) 35 E
129 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH? _____

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

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam & Lab Test
 (Signed) M. Bruce M. D.

(Address) 1801 Vine

*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 Wentworth Cem DATE OF BURIAL 6-30 1924

20. UNDERTAKER Natkins Bros. ADDRESS 1729 Lydia

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, 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 STATEMENT
BY PHYSICIAN.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 2487
 City..... (No.)..... St. Ward)

2. FULL NAME

Lillis Jensen
Madison

(a) Residence. No. 1715 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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

17. I HEREBY CERTIFY That I attended deceased from to 19, (that I last saw h..... alive on 19, and that death occurred, on the date stated above, at

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

Peritonitis following rupture of Pys Salfidex
of hospital

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

CONTRIBUTORY (SECONDARY) 40
 (duration) yrs. mos. da.

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? DATE OF

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

WAS THERE AN AUTOPSY?

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS?

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

(Signed) M. D. , 19 (Address)

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14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

15. FILED 6/30 24 M. M. Crowe REGISTRAR

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

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BY PHYSICIAN.

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50621