

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

Do not use this space.

15005

1. PLACE OF DEATH

County Jackson
Township Law
City Lansing

Registration District No. 399
Primary Registration District No. 1202
(No. 4007 Charlotte)

File No.
Registered No. 2021
St. Ward

2. FULL NAME

(a) Residence. No. 4007 Charlotte 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lathena Jenner</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct. 18 - 1867</u>				
7. AGE	YEARS <u>67</u>	MONTHS <u>6</u>	DAYS <u>19</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Retired Farmer</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) <input checked="" type="checkbox"/>				
(c) Name of employer				

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

PARENTS	10. NAME OF FATHER <u>Geo R Jenner</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Vir</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Helen Hite</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Vir</u> (STATE OR COUNTRY)	

14. INFORMANT Mrs. Lathena Jenner
(Address) 4007 Charlotte

15. FILED 5/8 25 M.M. Cerans REGISTRAR
Def

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1925
17. I HEREBY CERTIFY That I attended deceased from May 6 1925 to May 7 1925 that I last saw him alive on May 6 1925 and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asymptomatic Leukemia 65A
11A
54E (duration) yrs. 10 mos. ds.
CONTRIBUTORY Metastatic Growth
(SECONDARY) (duration) yrs. 2 mos. ds.

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

① DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Course
(Signed) Ralph Wilson, M.D.
5/8 1925 (Address) 920 Lathrop Bldg

*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 St Joseph Ho. DATE OF BURIAL May 9 1925

20. UNDERTAKER R. V. Leads by Sons ADDRESS Lady

PLAINLY, WITH CAREFUL INFORMATION SHOULD BE CAREFULLY OBTAINED IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY UNDERSTOOD. DEATH 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, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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.

My dear Sir:

With reference to your inquiry:-

With a given diagnosis of Lymphatic Leukemia, I don't understand how one can name a site for the primary seat of disease.

Secondly, the patient was first seen by me, when he was in extremis.

Assuring you that my desires are to cooperate in every respect, I await further instruction.

15005

Dear Sir:

It is essential that death certificates be made complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

20 20

PERMANENT RECORD

WITH UNFADING INK

Name: Hugh D. Tanner

Died at: Rainier City on May 7-1926

Residence: No. 400 2 Charlotte St.
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Place of birth (State or country) _____

Place of father (State or country) _____

Place of mother (State or country) _____

CAUSE OF DEATH: Lymphatic Leukemia

Contributory: Metastatic Growths
Non malignant glands

650

Was disease contracted? _____

Operation precede death? _____ Date of _____

Were an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: _____

Address of physician: _____

N. B. - Every CAUSE OF DEATH

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