

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

Do not use this space.

25469

1. PLACE OF DEATH

County JacksonRegistration District No. 408 397Township PrincePrimary Registration District No. 55550City Greenwood (No. 4234)File No. 25469

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. John H. Jennings 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. da.

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>Widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 26 - 1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>52</u>	<u>9</u>	<u>14</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Hillsville
(STATE OR COUNTRY) Virginia10. NAME OF FATHER Thomas Jennings11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)12. MAIDEN NAME OF MOTHER Mrs. Banks13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)14. INFORMANT Fred Jennings
(Address) Greenwood Mo.15. FILE NO. Aug 26 Mrs. F. L. Sumpster
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 - 192617. I HEREBY CERTIFY, That I attended deceased from Dead from 9:00 to 9:00 there that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute IndigestionCONTRIBUTOR (SECONDARY) Myo Carditis18. WHERE WAS DISEASE CONTRACTED Same.
IF NOT AT PLACE OF DEATH: _____19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) J. H. Sumpster, M. D.
, 19____ (Address) Greenwood 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 Greenwood Mo DATE OF BURIAL Aug 12 2620. UNDERTAKER T. L. Schick & Son ADDRESS St. Louis

AUG 25 1926

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson

Registration District No. 397

File No. _____

Township _____

Primary Registration District No. 4234

Registered No. _____

City Greenwood (No. _____)

St. _____ Ward) _____

2. FULL NAME

John H. Jennings

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

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

W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 26 1873

7. AGE

52 YEARS

9 MONTHS

14 DAYS

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

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer owner

9. BIRTHPLACE (CITY OR TOWN) Hillsville

(STATE OR COUNTRY) Virginia

10. NAME OF FATHER Thos Jennings

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia

12. MAIDEN NAME OF MOTHER Sarah Banks

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia

14. INFORMANT Fred Jennings
(Address) _____

15. FILED Aug. 26 1926 Mr F. Sample
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 - 1926

17. I HEREBY CERTIFY, That I attended deceased from _____
did before he got there, 19____
that I last saw him _____
death occurred, on the date stated above, at 630 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion super-
induced by depression heart
and Virginia Appendicitis
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY myocarditis
(SECONDARY)
(duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? symptoms
(Signed) J. G. Ragsdale, M. D.

, 19____ (Address) Lee's Summit 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

Greenwood Mo

DATE OF BURIAL

Aug. 12 1926

20. UNDERTAKER

H. L. Schick & Son

ADDRESS

Lee's Summit

N. B. - Every item on this certificate should be filled in exactly. Physicians of this state cause of death is not to 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.

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; Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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.

5-25469