

County Oregon Registration District No. 632 File No. \_\_\_\_\_  
 Township Thayer Primary Registration District No. 4382 Registered No. \_\_\_\_\_  
 Inc. Town or City Thayer (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

2 FULL NAME Louisa Jenkins  
 (a) Residence. No. \_\_\_\_\_ St., \_\_\_\_\_ Ward.  
 (Usual place of abode)  
 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.

If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Fe. 4 COLOR or RACE Wh 5 Single, Married, Widowed, or Divorced (write the word) Widow.

16 DATE OF DEATH Feb - 13 - 1930  
 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

6a If married, widowed, or divorced HUSBAND or (or) WIFE of Hiram Jenkins

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

6 DATE OF BIRTH Mar - 11 - 1848  
 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

and that death occurred, on the date stated above, at 8:20 p. m. The CAUSE OF DEATH was as follows:

7 AGE 81 Years \_\_\_\_\_ Months 11 Days 29  
 If LESS than 1 day, ..... hrs. or ..... min.

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.)

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

Cerebral apoplexy  
82A Apoplexy  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9 BIRTHPLACE (city or town) Unknown  
 (State or country) \_\_\_\_\_

CONTRIBUTORY (Secondary) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

10 NAME OF FATHER Unknown

18 Where was disease contracted? Home  
 If not at place of death \_\_\_\_\_

11 BIRTHPLACE OF FATHER (city or town) Unknown  
 (State or country) \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_  
 What operation performed? \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Unknown

Was there an autopsy? \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
 (State or country) \_\_\_\_\_

(Signed) Leo Carr M.D.  
March 13 1930 (Address) Coroner

14 Informant Leo Carr  
 (Address) Thayer Mo

19. PLACE OF BURIAL, CREMATION, or REMOVAL New Salem Cem. DATE OF BURIAL 3/14 30.

15 Filed March 26 1930  
G. A. Shea Registrar

20 UNDERTAKER Leo Carr ADDRESS Thayer

BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN, BOLD LETTERS. WITH UNFADING INK. THIS IS VERY IMPORTANT. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

**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,"

*Serum*, 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 HOMOCIDAL, 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.—Certificates may 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, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

**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 Oregon Registration District No. 632 File No. ....  
 Township ..... Primary Registration District No. 4382 Registered No. ....  
 City Thayer (No. ....) St. .... Ward)

**2. FULL NAME**

Louisa Jenkins  
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-1-1848

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ....., hrs. or ....., min.  
82 10 12

**8. OCCUPATION OF DECEASED**

(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) ..... (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

**14. INFORMANT**

(Address) Thayer 2630 to Rhea  
 FILED 19... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 13 19 38

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

\*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.

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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

F076-5