

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH
County Franklin
Township Chirviller
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 351 File No. 997
Primary Registration District No. 3492-208 Registered No. 3

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

FULL NAME Jenna Chambers

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Males</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Jan 25, 1912</u> (Month) (Day) (Year)		
AGE <u>19 yrs 4 mos 26 ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Ordinary work</u>		
BIRTHPLACE (City or town, State or foreign country) <u>State Mo</u>		
PARENTS	NAME OF FATHER <u>George Chambers</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>State Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Annie Nelson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>W.Va</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 25, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 23, 1912, to Jan 25, 1912, (that I last saw him alive on Jan 25, 1912, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Cardiac General Mangitia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY) (Duration) 2 yrs. _____ mos. 4 ds.

(Signed) E. J. Burnett M. D.
Jan 25, 1912 (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo J. Throckmorton
(ADDRESS) 1127 W. 2nd St
Filed Jan 26, 1912 J. J. Burnett REGISTRAR

PLACE OF BURIAL OR REMOVAL Graveside DATE OF BURIAL _____
UNDERTAKER Chas. Fisher ADDRESS _____

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*, *Sar-*

coma, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichaemia," "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.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PLACE OF BIRTH

County Henry
 Township Fairview
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

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

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

Registration District No. 35-1 File No. 997
 Primary Registration District No. 5492 Registered No. 3

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

FULL NAME James Chambers

PERSONAL AND STATISTICAL PARTICULARS

BEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Jan. 25 1912</u> <small>(Month) (Day) (Year)</small>		
AGE <u>19</u> yrs. <u>4</u> mos. <u>25</u> ds. <small>IF LESS than 1 day, ___ hrs. or ___ min.?</small>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Labourer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>		
PARENTS	NAME OF FATHER <u>Geo. Chambers</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Anna Nelson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Nebr.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 25 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 23 1912 to Jan 25 1912, that I last saw him alive on Jan 25 1912, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH was as follows:
Cerebrovascular
Wound infection Epidemic
(Duration) ___ yrs. ___ mos. 4 ds.

Contributory
(SECONDARY)
(Duration) 7 yrs. ___ mos. ___ ds.

(Signed) J. J. Fessenden M.D.
(Address) Deepwater Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Fessenden
(ADDRESS) Deepwater Mo.

Filed Jan 26 1912 J. J. Fessenden REGISTRAR

PLACE OF BURIAL OR REMOVAL
Brownington Cem

DATE OF BURIAL
Jan 26 1912

UNDERTAKER
Chas Richet

ADDRESS
Deepwater

JAN

* All information called for must be written on this Supplementary Certificate.

Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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