

STATE OF FLORIDA
BUREAU OF VITAL STATISTICS

Dr. Cass Ward

1 PLACE OF DEATH

STATE BOARD OF HEALTH

File No. _____

County *Duval*

CERTIFICATE OF DEATH

Registered No. _____

precinct _____
(Write name, not number)

Registration District No. _____

If death occurred
in a hospital or in-
stitution, give its
NAME instead of
street and number]

or
Inc. Town

Primary Registration Dist. No. _____

or
City

Jacksonville (No. *1703 Griffin Ave* St., _____ Ward)

2 FULL NAME

Annie Bliger

(a) Residence. No. *1703 Griffin Ave* St., _____ Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. 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** *widow*
Write the word)

5a If married, widowed, or divorced
HUSBAND of _____
(or) **WIFE** of *Mrs. Bliger*

6 DATE OF BIRTH _____, 1 _____
(Month) (Day) (Year)

7 AGE *57* yrs. mos. ds. **IF LESS than**
1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Laundress*
(b) General nature of industry, business, or establishment in which employed (or employer) *at home*
(c) Name of employer _____

9 BIRTHPLACE (city or town) *Savannah Ga*
(State or country)

10 NAME OF FATHER *Madison Townsend*
(City or Town) _____

11 BIRTHPLACE OF FATHER (State or country) _____

12 MAIDEN NAME OF MOTHER *Margie Tucker*

13 BIRTHPLACE OF MOTHER (City or Town) _____
(State or country)

14 Informant *Mrs. Bliger*
(Address)

15 Filled _____ 192 _____
Form V. S. No. 4 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) *Oct 4th 1922*

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h. _____ alive on _____, 19____
and that death occurred, on the date stated above, at *10 P.* m.

The **CAUSE OF DEATH*** was as follows:

(duration) yrs. mos. ds.

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**. (See reverse side for additional space.)

19 Place of Burial, Cremation, or Removal *Savannah Ga* **Date of Burial or Removal** *10/8 1922*

20 UNDERTAKER *Holmes* **ADDRESS** *City*

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

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, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Bronch 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 "Asthonia," "Anemia" (merely symptomatic, "Atrophy," "Collapse," "Coma," "Convulsions," "Debility") ("Congenital," "Senile," etc.), "Drop-sy," "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 carbonic 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.)

ALL CERTIFICATES MUST BE WRITTEN PLAINLY, WITH UNFADING BLACK INK.

INFORMANT'S SIGNATURE

Items 1 to 13, inclusive, must be made over the signature of the informant.

MEDICAL CERTIFICATE OF DEATH

Items 16 and 17 to be made over the signature of the physician or other person responsible for making this portion of the certificate.

UNDERTAKER'S SIGNATURE

All death certificates must be made over the signature of the Undertaker or person acting as such.

RUBBER STAMP SIGNATURES NOT PERMITTED

Informants, Physicians, Coroners, Undertakers and Registrars must not use rubber stamp signatures—death certificates will be permanently preserved, and to be of value for legal purposes—all signatures must be written with unfading black ink.

Funeral announcement later Sunday
Miss Capt. Sarah (DeVries)
Office relative & friends
1 daughter, Miss Eliza De Vries

Carroll
Jan 20, 1911

at home