

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 Jackson
Township Staw
Village _____
City Kansas City, Mo.

Registration District No. 399 File No. 13345
Primary Registration District No. 1002 Registered No. 1845

FULL NAME Robt Humphreys

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH UNKNOWN.
(Month) (Day) (Year)

AGE 23 yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) N. Y.

PARENTS NAME OF FATHER Andrew Humphrey

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Prockett
(ADDRESS) Lee Hosp.

Filed MAY 31 1910 Elmer Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 25th, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 10th, 1910, to May 25th, 1910, that I last saw him alive on May 25th, 1910, and that death occurred, on the date stated above, at 7:02 a.m.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) _____ yrs. _____ mos. 14 ds.

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

(Signed) S. J. Mead M. D.
5-30 1910 (Address) City Hosp

*State the Disease Causing Death, or, in deaths from Accident, 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. 15 ds. In the 6 yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death?

Former or usual residence 248 E. 14th

PLACE OF BURIAL OR REMOVAL Union DATE OF BURIAL May 31, 1910

UNDERTAKER E CARROLL-DAVIDSON UND. ADDRESS CC

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*.

of cause of death.—Name, first, the CAUSE OF DEATH (the primary affection with regard to causation), using always the same for the same disease. Examples: *Cerebritis* (the only definite synonym is "Epidemic meningitis"); *Diphtheria* (avoid use of *phoid fever* (never report "Typhoid Lobar pneumonia"; *Bronchopneumonia* unqualified, is indefinite); *Tuberculosis* of *lungs*, *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 septicaemia," "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.)

