

PHYSICIANS should state EXACTLY. 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 _____
 or
 Village Kansas City
 or
 City Mo. (NO. General Hospital Ward)

Registration District No. 399 File No. 17791
 Primary Registration District No. 1002 Registered No. 1683

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

FULL NAME Ziggie Tate

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Black SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)
 DATE OF BIRTH July 28, 1865
(Month) (Day) (Year)
 AGE 45 yrs. 9 mos. 12 ds. If LESS than 1 day, ___ hrs or ___ min.?

DATE OF DEATH May 10, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 4-22, 1911, to 5-10, 1911, that I last saw her alive on 5-10, 1911, and that death occurred, on the date stated above, at 7:40 p.m. The CAUSE OF DEATH* was as follows:

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

Carcinoma of Rectum
46D
 (Duration) 1 yrs. ___ mos. ___ ds.

BIRTHPLACE (City or town, State or foreign country) Missouri

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

PARENTS NAME OF FATHER John Tate
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri
 MAIDEN NAME OF MOTHER Fanny Black
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

(Signed) J.A. Orner M. D.
5-19, 1911 (Address) Old City Hospital

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J.A. Orner
 (ADDRESS) Old City Hospital

*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. 29 ds. In the State ___ yrs. ___ mos. 35 ds.
 Where was disease contracted if not at place of death? Not Known
 Former or usual residence Iowa

Filed MAY 1 1911 W.S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL Matte Bond Mo DATE OF BURIAL 5-12, 1911
 UNDERTAKER D.J. Moore ADDRESS 1820 E 18th St

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*; *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.)

