

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

PLACE OF DEATH

County Jackson.
Township Raw.
or
Village _____
or
City Kansas City. (NO. Old City Hospital St. _____ Ward _____)

Registration District No. 399 File No. 24540
Primary Registration District No. 1002 Registered No. 280

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

FULL NAME John Owens.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M. COLOR OR RACE White SINGLE MARRIED WIDOWED DIVORCED
(Write the word)

DATE OF DEATH June 29, 1911
(Month) (Day) (Year)

DATE OF BIRTH August 6, 1846
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 26, 1911, to June 29, 1911, that I last saw him alive on June 29, 1911, and that death occurred, on the date stated above, at 11:30 m.

AGE 64 yrs. 10 mos. 23 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

OCCUPATION (a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 3-57

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

BIRTHPLACE (City or town, State or foreign country) Tennessee.

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

NAME OF FATHER Jim Owens

(Signed) J. H. Whitcraft M. D.
6-20-1911 (Address) Old City Hospital.

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

MAIDEN NAME OF MOTHER Emma Owens

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

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. H. Whitcraft, M.D.

Where was disease contracted if not at place of death? _____
Former or usual residence. 66 + Trust

(ADDRESS) Old City Hospital

PLACE OF BURIAL OR REMOVAL Forest Hill DATE OF BURIAL July 1, 1911

Filed JUL 1 1911 W. S. Wheeler REGISTRAR

UNDERTAKER Carol Davidson ADDRESS Hud Co

1003 East 12

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 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.)



PLACE OF DEATH

County

Jackson

Township

or

Village

or

City

Kansas City

(NO.

Old City Hospital

St.:

Ward)

FULL NAME

John Owens.

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.

399

File No.

Primary Registration District No.

1002

Registered No.

2280

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Mr. white

widowed

DATE OF BIRTH

August 6, 1846
(Month) (Day) (Year)

AGE

64 yrs. 10 mos. 23 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)

Tennessee

NAME OF FATHER

Jim Owens

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

Ireland

MAIDEN NAME OF MOTHER

Emma Tuberculosis

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

Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. N. Whitcraft, M.D.

(ADDRESS)

Old City Hospital

Filed

1911

N. S. Wheeler

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

June 29, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

June 26, 1911, to June 29, 1911,
that I last saw him alive on " " " " 1911,

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

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

Contributory

(SECONDARY)

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

(Signed)

J. N. Whitcraft

M. D.

6-29-1911 (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. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

664 Troost

PLACE OF BURIAL OR REMOVAL

Forest Hill

DATE OF BURIAL

July 1, 1911

UNDERTAKER

ADDRESS

Carroll Davidson Und. Co.

Original file, date

July 1, 1911

All information called for must be written on this Supplementary Certificate

REPRODUCTION OF OCCUPATION IS VERY IMPORTANT.

Revised United States Standard Certificate of Death

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

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