

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Jackson

Township _____

Registration District No. 399File No. 24586

or Village _____

Primary Registration District No. 1002Registered No. 2329or City Kansas City(NO. 3512 East 12th st. St.: _____ Ward)

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

FULL NAME Mary Elizabeth Cole.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female	COLOR OR RACE White	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed
DATE OF BIRTH November 11, 1821. (Month) (Day) (Year)		
AGE 89 yrs. 7 mos. 23 ds. IF LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work Retired (b) General nature of industry, business, or establishment in which employed (or employer) O = O		
BIRTHPLACE (City or town, State or foreign country) Virginia		
PARENTS	NAME OF FATHER Charles Mc Queen	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia	
	MAIDEN NAME OF MOTHER Hester Huff	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Pratt(ADDRESS) 3512 East 12th st.Filed JUL 5 1911H. S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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DATE OF DEATH **July 4th 1911.**
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 20, 1911, to July 1, 1911, that I last saw her alive on July 1, 1911, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Senility
162 years
1911

(Duration) yrs. mos. ds.

Contributory Heart failure
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) W. A. Arnott M. D.
7-5-1911 (Address) W. B. Deardoff

*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 _____

PLACE OF BURIAL OR REMOVAL

Brookfield, Mo.

DATE OF BURIAL

7/6/11 1911

UNDERTAKER

Freeman & Marshall

ADDRESS

3146 Main 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*, *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*, *peritonacum*, 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.)

