

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.

PLACE OF DEATH

County Jackson
 Township Kear
 or
 Village _____
 or
 City Kansas City Mo.

Registration District No. 399
 Primary Registration District No. 1002
 City 1023 West 17 St. _____ Ward _____

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

File No. 31451
 Registered No. 2997

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

FULL NAME Israel Field

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widow</u>
DATE OF BIRTH <u>Feb 15 1841</u> (Month) (Day) (Year)		
AGE <u>70</u> yrs. ____ mos. ____ ds.		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Merchant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>4-03-08</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 5 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1911, to Sept 5, 1911, that I last saw him alive on Sept 5, 1911, and that death occurred, on the date stated above, at 10⁶³ m.

The CAUSE OF DEATH* was as follows:
Chronic Cystitis
174-13570

(Duration) ____ yrs. 6 mos. ____ ds.

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

PARENTS	NAME OF FATHER <u>Marcus Field</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Hungary</u>
	MAIDEN NAME OF MOTHER <u>Ester Field</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Hungary</u>

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

(Signed) A. Hoff M. D.
Sept 6 1911 (Address) 118 248 Broadway

*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 1023 West 17

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Leo H. Field
 (ADDRESS) 2726 Harrison

PLACE OF BURIAL OR REMOVAL <u>Elmwood</u>	DATE OF BURIAL <u>Sept 7 1911</u>
UNDERTAKER <u>Carroll Davidson & Co</u>	ADDRESS <u>1003 East 12</u>

Filed SEP 7 1911 W. J. Wheeler REGISTRAR

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*, *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.)



REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

County Jackson

Township _____

or

Village _____

or

City Kansas City(NO. 1023 West 17

St. _____ Ward _____

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

FULL NAME

Israel Field

399

Registration District No. _____

File No. _____

1002

Primary Registration District No. _____

Registered No. _____

2997

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

male

COLOR OR RACE

whiteSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)widower

DATE OF DEATH

Sept. 5

(Month)

(Day)

1911
(Year)

DATE OF BIRTH

Feb. 15

(Month)

(Day)

1841
(Year)

AGE

70

yrs.

mos.

ds.

IF LESS than
1 day, _____ hrs.
or _____ min.I HEREBY CERTIFY, that I attended deceased from June 1, 1911, to Sept. 5, 1911, that I last saw him alive on _____, 1911, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

OCCUPATION

(a) Trade, profession, or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

X Clothing

BIRTHPLACE

(City or town,

State or foreign country)

Hungary(Duration) _____ yrs. 6 mos. _____ ds.

NAME OF FATHER

Marcus Field

Contributory

(SECONDARY)

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

BIRTHPLACE OF FATHER

Hungary

(Signed)

A. J. Kopf

M. D.

Sept. 6, 1911 (Address) 1824 Summit

MAIDEN NAME OF MOTHER

Esther unknown

*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

Hungary

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)

Leo A. Field

Where was disease contracted if not at place of death?

Former or usual residence 1023 West 17

(ADDRESS)

2726 Harrison

PLACE OF BURIAL OR REMOVAL

Elmwood

DATE OF BURIAL

Sept. 7, 1911

Filed

NOV 61911W. S. Wheeler

UNDERTAKER

ADDRESS

REGISTRAR

Carroll Davidson and Co. 1003 E. 12

Original file date

SEP 71911

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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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.)

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