

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

PLACE OF DEATH
County Jackson
Township Kan
or
Village Kansas
or
City City Mo (NO. 503 A-16th)

Registration District No. 300 File No. 31501
Primary Registration District No. 1002 Registered No. 3048
St. _____ Ward _____

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

FULL NAME Infant Child White

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH unknown
(Month) (Day) (Year)

AGE about If LESS than 1 day, ____ hrs. or ____ min.?
____ yrs. ____ mos. 2 ds.

OCCUPATION
a) Trade, profession, or particular kind of work none
b) General nature of industry, business, or establishment in which employed (or employer) "

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

PARENTS
NAME OF FATHER Albert Knorr
BIRTHPLACE OF FATHER (City or town, State or foreign country) "
MAIDEN NAME OF MOTHER "
BIRTHPLACE OF MOTHER (City or town, State or foreign country) "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W E Stewart

(ADDRESS) 1212 M^e Gess^{er}

Filed SEP 13 1911 W. S. Wheelie
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH about Sept 9th, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* was as follows:
Asphyxia by hanging handschief around neck
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) _____
(Duration) ____ yrs. ____ mos. ____ ds.
(Signature) W E Stewart M. D.
(Address) 1212 M^e Gess^{er}

*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 Mt Hope K C DATE OF BURIAL Sept 13 1911

UNDERTAKER W E Stewart ADDRESS 1212 M^e Gess^{er}

United States Standard Certificate of Death

U. S. Census and American Public Health Association]

of occupation.—Precise statement of occupation, very important, so that the relative health-irious pursuits can be known. The question to each and every person, irrespective of any occupations a single word or term on will be sufficient, e. g., *Farmer* or *Planter*, *Composer*, *Architect*, *Locomotive engineer*, *Teacher*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to give (a) the kind of work and also (b) the name of the business or industry, and therefore an example is provided for the latter statement; it is to be used only when needed. As examples: (a) *Cotton mill*; (b) *Salesman*, (b) *Grocery store*, (b) *Automobile factory*. The material given may form part of the second statement. Examples: "Laborer," "Foreman," "Manager," etc., without more precise specification, as *Farm laborer*, *Laborer—Coal mine*, etc. For persons at home, who are engaged in the duties of the only (not paid *Housekeepers* who receive a salary), may be entered as *Housewife*, *Householder*, *At home*, and children, not gainfully employed, as *At home*. Care should be taken to recite the occupations of persons engaged in service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given in part of the DISEASE CAUSING DEATH, state date of beginning of illness. If retired from occupation may be indicated thus: "Retired from occupation." For persons who have no occupation 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 term for the same disease. Examples: *Cerebral meningitis*; *Diphtheria* (never *unqualified*, is indefinite); *Typhoid fever* (never *unqualified*, is indefinite); *Lobar pneumonia*; *Bronchopneumonia*; *Unqualified*, is indefinite); *Peritonitis*, etc., *Causes*.

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," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "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.)

State the Disease Causing Death
 Name of Injurer; and (??) whether
 (Add) _____ 1911 _____

DATE OF RESIDENCE (FOR
 AT RESIDENTS)

AGE

SEX

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

PLACE OF BURIAL OR REMOVAL

SIGNATURE OF DEATH REPORTER

