

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Jackson

Township _____

Registration District No. 899File No. 41379

Village _____

Primary Registration District No. 1002Registered No. 3835City Kansas city (NO. 702 East 5th St. 6 Ward)

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

FULL NAME Milia Koury

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX fm COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) singleDATE OF DEATH Dec 3, 1911
(Month) (Day) (Year)DATE OF BIRTH July 26, 1910
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Nov 9, 1911, to Dec 3rd, 1911, that I last saw her alive on Dec 2nd, 1911, and that death occurred, on the date stated above, at 9 a.m. The CAUSE OF DEATH* was as follows:AGE 1 yrs. 4 mos. 7 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work noneCerebro-Spinal Meningitis(b) General nature of industry, business, or establishment in which employed (or employer) none18 (Duration) ___ yrs. ___ mos. 13 ds.BIRTHPLACE (City or town, State or foreign country) Kansas city, MoContributory (SECONDARY) Pneumonia (Duration) ___ yrs. ___ mos. 24 ds.NAME OF FATHER John Koury(Signed) Geo. A. Graham M. D. Dec 3, 1911 (Address) 806 Rialto BldgBIRTHPLACE OF FATHER (City or town, State or foreign country) Severn

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

MAIDEN NAME OF MOTHER Mila Koury

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

At place of death ___ yrs. ___ mos. ___ ds. In the ___ yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) John Koury

Former or usual residence _____

(ADDRESS) 702 East 5thPLACE OF BURIAL OR REMOVAL St. Marys DATE OF BURIAL Dec 4, 1911DEC 4 1911 W.S. WheelerUNDERTAKER A. Delbeto & Co. ADDRESS 603 East 5th

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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*, *peritonaeum*, 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.)



County Jackson Registration District No. 399 File No. 41379
 Township _____ or _____ Village _____ or _____ City Kansas City (NO. 702 East-5th St.; 6 Ward) Registered No. 3835-

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

FULL NAME Milvia Koury

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
 DATE OF BIRTH July 26, 1910 (Month) (Day) (Year)
 AGE 1 yrs. 4 mos. 7 ds. If LESS than 1 day, hrs. or min. 2
 OCCUPATION (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 3, 1911 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Nov. 9, 1911, to Dec. 3, 1911, that I last saw her alive on Dec. 2, 1911, and that death occurred, on the date stated above, at 9 a.m.
 The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis
(epidemic)

BIRTHPLACE (City or town, State or foreign country) Kansas City, Mo.
 NAME OF FATHER John Koury
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
 MAIDEN NAME OF MOTHER Milva Karr
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

(Duration) _____ yrs. _____ mos. 13 ds.
 Contributory (SECONDARY) Pneumonia
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Geo. A. Graham M. D.
Dec. 3, 1911 (Address) 806 Walnut Bldg.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Koury
 (ADDRESS) 702 East 9th

*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 _____

FILED FEB 7 1911
 Registrar W.S. Wheeler

PLACE OF BURIAL OR REMOVAL Mt. St. Marys DATE OF BURIAL Dec. 4, 1911
 UNDERTAKER A. S. S. & Co. ADDRESS 603 E. 5th

Revised United States Standard Certificate of Death

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

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