

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 JacksonTownship Kaw

Village \_\_\_\_\_

City Kansas City

C. H. Lytle 899

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002File No. 5251Registered No. 486

## FULL NAME

C. H. Lytle

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

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Not known</u> , 18 <u>68</u> (Month) (Day) (Year)		
AGE <u>44</u> <u>35</u> yrs. mos. ds.		If LESS than 1 day, hrs. or min.?

OCCUPATION  
(a) Trade, profession, or particular kind of workBarber

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

BarberBIRTHPLACE  
(City or town, State or foreign country)3-01 Missouri Lincoln

PARENTS	NAME OF FATHER <u>Geo Lytle</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>no</u>
	MAIDEN NAME OF MOTHER <u>Clarice Hill</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Rockport Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Walker(ADDRESS) Liberty Mo

FEB 11 1912

Filed 191 W. S. Wheeler REGISTRARMISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

February 10, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 4, 1912, to Feb. 10, 1912, that I last saw him alive on Feb. 10, 1912, and that death occurred, on the date stated above, at 10:55 am. The CAUSE OF DEATH\* was as follows: 11  
1138

61  
Contributory Lobar pneumonia  
(SECONDARY)  
(Duration) yrs. mos. 6 ds.  
(Signed) Frank C. Teachenor M. D.  
Feb. 10, 1912 (Address) General 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. 5 ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence 401 Myndotti St

PLACE OF BURIAL OR REMOVAL

Liberty Mo

DATE OF BURIAL

Feb 11, 1912

UNDERTAKER

Maurice M. Duesch

ADDRESS

3015 Main

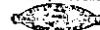
# Revised United States Standard Certificate of Death

[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: (d) *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-*

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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.)



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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 \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Kansas City (NO. General Hospital St.: \_\_\_\_\_ Ward)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Registration District No. 399 File No. 5251  
Primary Registration District No. 1002 Registered No. 466

FULL NAME Chas. H. Lytleliter ([If death occurred in a hospital or institution, give its NAME instead of street and number])

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single  
DATE OF BIRTH Date unknown 1868  
(Month) (Day) (Year)  
AGE 44(?) If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min. \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

DATE OF DEATH Feb. 10, 1912  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from Feb. 4, 1912, to Feb. 10, 1912, that I last saw him alive on Feb. 10, 1912, and that death occurred, on the date stated above, at 10:35 a.m.

OCCUPATION (a) Trade, profession, or particular kind of work Barber  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:  
Cerebrospinal meningitis epidemic

BIRTHPLACE (City or town, State or foreign country) Missouri Lenoors

(Duration) \_\_\_ yrs. \_\_\_ mos. 6 ds.  
Contributory Lobar pneumonia  
(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 2 ds.

PARENTS NAME OF FATHER Geo. Lytleliter  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Columbia, Mo.  
MAIDEN NAME OF MOTHER Charice Hill  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rockport, Mo.

(Signed) Frank R. Peacheur M. D.  
Feb. 10, 1912 (Address) General Hospital  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Harvey Walker  
(ADDRESS) Liberty, Mo.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. 5 ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted If not at place of death?  
Former or usual residence 401 Wyandotte St.

Filed APR 9 1912 W.S. Wheeler  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Liberty Mo. DATE OF BURIAL Feb. 11, 1912  
UNDERTAKER Maurice M. Suerk ADDRESS 3015 Main

# Revised United States Standard Certificate of Death

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

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