

MARGIN RESERVED FOR BINDING

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.

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

PLACE OF DEATH
County Jackson
Township _____ or Village _____ or City Ramsey City (NO. 13/162 St. _____ Ward _____) Registration District No. 389 File No. 5480
Primary Registration District No. 1002 Registered No. 693
FULL NAME Jay Emma Ross (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single (If write the word)
DATE OF BIRTH Feb 22, 1912 (Month) (Day) (Year)
AGE _____ yrs. _____ mos. 5 ds. If LESS than 1 day, _____ hrs. or _____ min.?
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) Missouri
PARENTS
NAME OF FATHER Jacob H. Ross
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.
MAIDEN NAME OF MOTHER Jessie M. Gorman
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 27, 1912 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Feb 22, 1912, to Feb 27, 1912, that I last saw him alive on Feb 27, 1912, and that death occurred, on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Convulsion
caused by Pressure on Brain
(Duration) _____ yrs. _____ mos. 5 ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. S. Strother M. D.
2624, 1912 (Address) 924 Rialto
*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. 5 ds.
Where was disease contracted if not at place of death?
Former or usual residence None

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Ross
(ADDRESS) 316 Jackson Ave
Filed 528 28 W. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL Mt. Washington Ave
DATE OF BURIAL Feb 27, 1912
ADDRESS 624 Westport

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*, *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.)



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.

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

PLACE OF DEATH
 County Jackson
 Township _____
 or
 Village _____
 or
 City Kansas City (NO. 1316 Jackson St.; _____ Ward)

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

Registration District No. 399 File No. 5480
 Primary Registration District No. 1002 Registered No. 695

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

FULL NAME Jay Ennis Ross

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Feb. 22</u> , 191 <u>2</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. <u>9</u> ds. IF LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>mo. Ill.</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 27, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 22, 1912, to Feb. 27, 1912, that I last saw him alive on Feb. 27, 1912, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Convulsions
caused by pressure on
Brain - injury at birth.

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

PARENTS

NAME OF FATHER <u>Jacob H. Ross</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>
MAIDEN NAME OF MOTHER <u>Jess M. Garman</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kansas</u>

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

(Signed) J. S. Strother M. D.
Feb. 28, 1912 (Address) 927 Realto

*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. 5 ds.

Where was disease contracted if not at place of death?
 Former or usual residence none

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. H. Ross
 (ADDRESS) 316 Jackson Ave.

PLACE OF BURIAL OR REMOVAL <u>Mt. Washington</u>	DATE OF BURIAL <u>Feb. 28</u> , 191 <u>2</u>
UNDERTAKER <u>R. V. Lindsey</u>	ADDRESS <u>427 Westport.</u>

APR 9 1912
N.S. Wheeler
 REGISTRAR

Revised United States Standard Certificate of Death

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

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