PLACE OF DEATH

County Jackson

Township Kaw

or

Village

or

City Kansas City Mo (NO. 908 East 11th St.; Ward)

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

Registration District No. 899 1

File No. 9614

Primary Registration District No. 1002

Registered No. 1112

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

FULL NAME Anna Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	married

DATE OF BIRTH May (Month) 26 (Day), 1884 (Year)

AGE 27 yrs. 10 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) General G-O

BIRTHPLACE (City or town, State or foreign country) Atchison Kansas

PARENTS

NAME OF FATHER William H Miller

BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.

MAIDEN NAME OF MOTHER Katherine McDonald

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. L. Bradford

(ADDRESS) 1024 Harrison

Filed MAR 28 1912 W. S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar (Month) 27 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 1, 1912 to Mar 27, 1912 that I last saw her alive on Mar 27, 1912 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Anemia

130
918

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Nephritis

8 (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Jos Robinson M. D.

Mar 28, 1912 (Address) Kansas City Mo.

*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	DATE OF BURIAL
Mt. St. Marys	March 29 1912
UNDERTAKER	**ADDRESS**
Mrs. C. L. Forster	918 Brooklyn

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 c. es, 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, Sarcoma,* 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 *septichaemia,*" "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.)

HUGH STEPHENS, JEFFERSON CITY.

PLACE OF DEATH

County Jackson

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

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

Township ____ Registration District No. 399 File No. ____

or Village ____ Primary Registration District No. 1002 Registered No. 1112

or City Kansas City (NO. 908 East 11th St.; ____ Ward)

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

FULL NAME Anna Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX F | COLOR OR RACE w | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) m

DATE OF BIRTH May 26, 1884 (Month) (Day) (Year)

AGE 27 yrs. 10 mos. 1 ds. | If LESS than 1 day, ____ hrs. or ____ min.

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

BIRTHPLACE (City or town, State or foreign country) Atchison Kans

PARENTS
NAME OF FATHER William H. Miller
BIRTHPLACE OF FATHER (City or town, State or foreign country) Pa
MAIDEN NAME OF MOTHER Katherine McDonald
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. L. Bradford

(ADDRESS) 1024 Harrison

Filed MAY 9 1912, 191__ W. S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 27, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 1, 1912, to Mar 27, 1912, that I last saw her alive on Mar 27, 1912, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Arenina

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

Contributory (SECONDARY) Nephritis Acute

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

(Signed) J. Robinson Rex M.D.

3/28, 1912 (Address) Kansas City Mo

*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 Rt Marys | DATE OF BURIAL Mar 29 1912

UNDERTAKER Mrs C. L. Forester | ADDRESS 918 Brookline Ave

SUPPLEMENTARY

Original file, date MAR 28, 1912 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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