

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.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX 7	COLOR OR RACE W	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) Single	DATE OF DEATH 3 April 6, 1912 (Month) (Day) (Year)		
DATE OF BIRTH Aug 11, 1883 (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from March 14, 1912, to April 6, 1912, that I last saw him alive on April 6, 1912, and that death occurred, on the date stated above, at 11 ³⁰ a.m. The CAUSE OF DEATH* was as follows: Pneumonia, General, 12 10		
AGE 27 yrs. mos. ds. IF LESS than 1 day, hrs. or min.?			(Duration) yrs. mos. 6 ds.		
OCCUPATION (a) Trade, profession, or particular kind of work Nurse (b) General nature of industry, business, or establishment in which employed (or employer) 9-35			Contributory (Signed) B. C. Guffitt M. D. April 6, 1912 (Address) 1725 Realtors		
BIRTHPLACE (City or town, State or foreign country) Mo			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
PARENTS	NAME OF FATHER Jacob Brookhart	BIRTHPLACE OF FATHER (City or town, State or foreign country) Ma	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.		
	MAIDEN NAME OF MOTHER Laura Bohrer	BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky	Where was disease contracted If not at place of death? Former or usual residence.		
	THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) N. H. Brookhart M. D. (ADDRESS) Columbus, Mo.		PLACE OF BURIAL OR REMOVAL Harrisonville Mo		
	FILED APR 7 1912 191		REGISTRAR W. S. Wheeler		DATE OF BURIAL Apr. 9, 1912 ADDRESS 1109 Cedar

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

PLACE OF DEATH
County Jackson
Township _____ Registration District No. 399 File No. 13491
Village _____ Primary Registration District No. 1002 Registered No. 1275
or _____
City Kansas City (NO. 17108) St. _____ Ward _____
FULL NAME Harrison W. Brookhart
(If death occurred in a hospital or institution, give its NAME instead of street and number)

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*, *Composer*, *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.)



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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

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

County Jackson

Township _____

Registration District No. 399

File No. 13491

Village _____

Primary Registration District No. 1002

Registered No. 1275

City Kansas City (NO. 710 Perin St. _____ Ward _____)

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

FULL NAME Marion W. Brookhart

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED S. (Write the word)

DATE OF DEATH Apr 6, 1912 (Month) (Day) (Year)

DATE OF BIRTH Aug. 11, 1883 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 14, 1912, to Apr 6, 1912, that I last saw her alive on Apr 6, 1912, and that death occurred, on the date stated above, at 11:30 a.m.

AGE 27 yrs. _____ mos. _____ 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 nurse (b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory Pleurisy
Staphylococci with general systemic febrile fluency.
(Duration) _____ yrs. _____ mos. 6 ds.

BIRTHPLACE (City or town, State or foreign country) Mo. Mo.

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

NAME OF FATHER Jacob Brookhart

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

MAIDEN NAME OF MOTHER Laura Bohm

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

(Signed) A. C. Griffith M. D. Apr. 6, 1912 (Address) 1225 Rialto Bldg.

*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

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

(Informant) H. N. Brookhart

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) Columbus

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

Former or usual residence _____

Fix _____ 1912 W. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL Warrenville Mo DATE OF BURIAL Apr 9, 1912

UNDERTAKER J. F. Dammell & Co. ADDRESS 1109 Bday

APR 7, 1912

Original file date _____ 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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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.)