

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 Naw or Village _____
or City Kansas City (NO. General Hospital St. _____ Ward _____)
Registration District No. 399 File No. 13567
Primary Registration District No. 1002 Registered No. 1351
FULL NAME W. M. Kelly Faulk
(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 Widowed
(Write the word)
DATE OF BIRTH Nov. 29, 1850
(Month) (Day) (Year)
AGE 61 yrs. 4 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer) Stone Mason
BIRTHPLACE (City or town, State or foreign country) Indiana
PARENTS
NAME OF FATHER John Kelly
BIRTHPLACE OF FATHER (City or town, State or foreign country) New Jersey
MAIDEN NAME OF MOTHER Anna Ziebachoff
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pennsylvania

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 30, 1922
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from 3-25, 1922, to 3-30, 1922, that I last saw him alive on 3-30, 1922, and that death occurred, on the date stated above, at 10:20 P. M.
The CAUSE OF DEATH* was as follows:
Ruptured hepatic abscess.
1230 (Duration) ? yrs. ___ mos. ___ ds.
Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) D. M. Aron M. D.
4-4, 1922 (Address) K. C. Gould Hosp.
*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 _____
PLACE OF BURIAL OR REMOVAL Shoreline Hill DATE OF BURIAL 4-11, 1922
UNDERTAKER Quirk and Wipon ADDRESS 3033 Main

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dora L. Leichhardt
Record Clerk
(ADDRESS) General Hospital
Filed APR 11 1922 W. S. Wheeler REGISTRAR

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, peritoneum*, 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.)



WHILE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Jackson

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

Township _____

Registration District No. 399

File No. 13567 ✓

or Village _____

Primary Registration District No. 1002

Registered No. 13571

or City Kansas City (NO. General Hosp.)

St. _____ Ward _____

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

FULL NAME W. Faulk

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED wid.
(Write the word)

DATE OF BIRTH Nov. 29, 1850
(Month) (Day) (Year)

AGE 61 yrs. 4 mos. 1 ds. IF LESS than 1 day, _____ hrs. or _____ mins.

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

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

PARENTS NAME OF FATHER John Faulk
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind.
MAIDEN NAME OF MOTHER Anna Zichahoff
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pa.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Dora L. Leichardt
(ADDRESS) Gen. Hospital

File X 1009 1912 W. S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 30, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 25, 1912, to Mar. 30, 1912, that I last saw him alive on Mar 30, 1912, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:
Ruptured hepatic abscess
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) P. M. Aves M. D.
Apr. 4, 1912 (Address) General Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (f) 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 Forest Hill DATE OF BURIAL Apr 11, 1912
UNDERTAKER Quirk & Dixon ADDRESS 3033 Main

Original file, date. APR 11, 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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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 "Asthemia," "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.)