

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. General Hospital Ward)

Registration District No. 282 File No. 26258  
Primary Registration District No. 1003 Registered No. 2589

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

FULL NAME William Rogers

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH November 6<sup>th</sup> 1864  
(Month) (Day) (Year)

AGE 48 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Laborer Met. Str. Ry  
(b) General nature of industry, business, or establishment in which employed (or employer) 4-7

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

NAME OF FATHER Arsbit Rogers

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

MAIDEN NAME OF MOTHER Unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. A. Thissen  
(ADDRESS) 2309 Chamfallet

Filed AUG 8 1912 W. S. Whaley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 7<sup>th</sup> 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 6<sup>th</sup> 1912, to Aug 7<sup>th</sup> 1912, that I last saw him alive on Aug 7<sup>th</sup> 1912, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH\* was as follows:

Ac Abscess of liver involving whole of right lobe.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Amoebic dysentery.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) R. Porter M. D.  
(Address) General 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. \_\_\_\_\_ ds. In the \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence 1210 1/2 Virginia St. K.C.

PLACE OF BURIAL OR REMOVAL Forest Hill DATE OF BURIAL Aug 8 1912

UNDERTAKER Imus + Thissen ADDRESS 1804 E. 15.

# 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*, *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 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.)

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

PLACE OF DEATH  
County Jackson  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Kansas City (NO. General Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 399 File No. \_\_\_\_\_  
Primary Registration District No. 1002 Registered No. 2589

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

FULL NAME William Rogers

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Aug. 7, 1912  
(Month) (Day) (Year)

DATE OF BIRTH Nov. 6, 1864  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 5, 1912, to Aug. 7, 1912, that I last saw him alive on Aug. 7, 1912, and that death occurred, on the date stated above, at 9 a., m.

AGE 48 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 Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) Mkt. Street

Abscess of liver  
involving entire right lobe. Amoebic.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

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

Contributory Amoebic Dysentery  
(SECONDARY) (Duration) 5 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER Nesbit Rogers

(Signed) R. C. Porter M. D.  
Aug. 7, 1912 (Address) General Hosp.

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

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER Unknown

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

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

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted If not, at place of death? \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) C. A. Thersen

Former or usual residence \_\_\_\_\_

(ADDRESS) 2309 Champell St

PLACE OF BURIAL OR REMOVAL Forest Hill DATE OF BURIAL Aug. 8, 1912

FILED OCT 19 1912 REGISTRAR W.S. Wheeler

UNDERTAKER Muen & Thersen ADDRESS 1804 E. 15th

# Revised United States Standard Certificate of Death

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

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**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*, *Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

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