

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. 4000 Penn)

Registration District No. 200
Primary Registration District No. 1002

File No. 26316
Registered No. 2647

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

FULL NAME Adeline Bass

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH June 21, 1870
(Month) (Day) (Year)

AGE 72 yrs. 1 mos. 23 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) None

BIRTHPLACE (City or town, State or foreign country) Illinois Woodstock Ill.

NAME OF Unknown

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

MAIDEN NAME OF MOTHER Lucy Woodstock

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Bass
(ADDRESS) 4000 Penn

AUG 14 1912
W.S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 13th, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 23, 1912, to Aug 13th, 1912, that I last saw her alive on Aug 13th, 1912, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
A Hemiplegia
D from
B cerebral hemorrhage
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory subluxation of cervical vertebrae
(SECONDARY) producing pressure particularly on vasomotor and trophic nerves
(Signed) B. W. Lundberg, C.S., M.D., D.O.
Aug 14, 1912 (Address) 327 Shafter Bldg

*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 Bellevue Cemetery DATE OF BURIAL Aug 16, 1912

UNDERTAKER W. H. Raymond ADDRESS Kansas City

Kenn

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*, *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*," "*Hæmorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uracmia*," "*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. 4000 Penn.)

Registration District No. 399 File No. _____
Primary Registration District No. 1002 Registered No. 2647
St. _____ Ward _____

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

FULL NAME Adeline Saxe

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>widow</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>Aug. 13</u> , 191 <u>2</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>June 21</u> , 18 <u>40</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>June 23</u> , 191 <u>2</u> , to <u>Aug. 13</u> , 191 <u>2</u> , that I last saw her alive on <u>Aug. 13</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>3 p.</u> m.		
AGE <u>72</u> yrs. <u>1</u> mos. <u>23</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.	The CAUSE OF DEATH* was as follows: <u>I do not know. I can only report conditions as I find them. We often find the cause in some severe fall, if he recalled such a cause years ago, and in order to produce the post-mortem of her blood vessels in her brain, the thoracic nerves must have been (Duration) <u>15</u> hrs. <u>15</u> ds. to well stand to their work for many years.</u>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds. (Signed) <u>B. W. Lindberg M. D. M.D.</u> <u>Aug. 4</u> , 191 <u>2</u> (Address) <u>327 Shubert Bldg.</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Woodside Ill.</u>			* 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 <u>Unknown</u>	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>	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 <u>Unknown</u>	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ill.</u>	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) <u>Edward Saxe</u> (ADDRESS) <u>4000 Penn.</u>			PLACE OF BURIAL OR REMOVAL <u>Bethel Cemetery</u>	
	NOV 2 1912 Filed _____ 191 <u>2</u> REGISTRAR <u>W. S. Whaley</u>			DATE OF BURIAL <u>Aug. 16</u> , 191 <u>2</u> ADDRESS <u>Kansas City</u>	

Revised United States Standard Certificate of Death

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

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