

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 Kaw Registration District No. 399 File No. 36033
Village _____ Primary Registration District No. 1002 Registered No. 3432
or _____
City Kansas City (NO. General Hospital St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Minnie Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
DATE OF BIRTH <u>May 24</u> , 18 <u>90</u> (Month) (Day) (Year)		
AGE <u>42</u> yrs. <u>5</u> mos. <u>8</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-0</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		
PARENTS	NAME OF FATHER <u>Steve Branstetter</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	MAIDEN NAME OF MOTHER <u>America Hickey</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 2, 192
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11/1, 192; to 11/2, 192; that I last saw her alive on 11/2, 192; and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:
Shock (Post-operative)
(operation was laparotomy)
(Duration) ___ yrs. ___ mos. 1 ds.

Contributory old pelvic inflammation
with cellulitis adhesions
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) L. S. Jokus M. D.
11/3, 192 (Address) E. C. Guil Hospital

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dora L. Leichhardt
Record clerk
(ADDRESS) General Hospital
W. S. Wheeler
REGISTRAR

NOV 4 1912

*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. 8 ds. In the State ___ yrs. ___ mos. ___ ds.

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

Former or usual residence 216 Monroe

PLACE OF BURIAL OR REMOVAL <u>Forest Hill</u>	DATE OF BURIAL <u>Nov 4</u> , 19 <u>2</u>
UNDERTAKER <u>J. P. Rose</u>	ADDRESS <u>3828 Delap Ave</u>

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," "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 carbonic 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.)

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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. 3432

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

FULL NAME Minnie Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Nov. 2, 1912
(Month) (Day) (Year)

DATE OF BIRTH May 24, 1870
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11/1/12, 1912, to 11/2, 1912, that I last saw her alive on _____, 1912, and that death occurred, on the date stated above, at 3:45 P.

AGE 42 yrs. 5 mos. 8 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Shock (Post operative) & operation was Laparotomy

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

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

(Duration) _____ yrs. _____ mos. (1) ds.
Contributory Old Pelvic inflammation with extensive adhesions
(Signed) L. S. Johnston M. D.
1/3 1912 (Address) R.C. Gen. Hosp.

NAME OF FATHER Steve Branhart

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

MAIDEN NAME OF MOTHER Amelia Mickey

BIRTHPLACE OF MOTHER (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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. 8 ds. In the State _____ yrs. _____ mos. _____ ds.

(Informant) Dora L. Leichhardt

Where was disease contracted If not at place of death? _____
Former or usual residence 216 Monroe

(ADDRESS) Record Clerk.

PLACE OF BURIAL OR REMOVAL Forest Hill DATE OF BURIAL Nov. 4, 1912

Filed Nov. 4, 1912 W.S. Wheeler REGISTRAR

UNDERTAKER J. P. Rose ADDRESS 3828 Independence

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.

PLEASE PRINT FULL NAME OF DECEASED IN THIS IS A PERMANENT RECORD

Original file, date Nov 4, 192 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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