

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

PLACE OF DEATH
County Jackson
Township Kaw
Village Kansas City Mo
City Kansas City Mo (No. 1814 Montgall St.: _____ Ward) _____

Registration District No. 3997 File No. 1521
Primary Registration District No. 1002 Registered No. 345

FULL NAME Anna Peters

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Aug 9th 1888
(Month) (Day) (Year)

AGE 24 yrs. 5 mos. 20 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER James Brady
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland
Maiden Name of Mother Anna Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 29th 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from as coroner, 1913, to _____, 1913, that I last saw h _____ alive on _____, 1913, and that death occurred, on the date stated above, at 7³⁰ m.

The CAUSE OF DEATH* was as follows:
Chloroform narcosis
11:30

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

(Signed) Harry Czarlinsky M. D.
1/30/13 (Address) Com Bldg Coroner

*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 1814 Montgall

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Bathurst
(ADDRESS) 16 South 7th St

JAN 30 1913
Filed _____ 1913 W.S. Wheely REGISTRAR

PLACE OF BURIAL OR REMOVAL Edgerton Mo DATE OF BURIAL Jan 31 1913
UNDERTAKER Carroll Davidson ADDRESS 3024 Troost

Exact statement of OCCUPATION is very important.

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^v 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, 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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, very important.

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. 1814 Montgall St.: _____ Ward) _____

Registration District No. 399 File No. _____
Primary Registration District No. 1002 Registered No. 345

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

FULL NAME

Anna Peters

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(# Write the word)
DATE OF BIRTH Aug. 9, 1888
(Month) (Day) (Year)
AGE 24 yrs. 5 mos. 20 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) _____

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

PARENTS
NAME OF FATHER James Brady
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland
MAIDEN NAME OF MOTHER Anna Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Bathurst
(ADDRESS) 16 South 7th K.C.K.

Filed MAR -7 1913 1913 W.S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 29, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ascaporia, to _____, 1913, that I last saw h_____ alive on _____, 1913, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:
Chloroform narcosis
suicide
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Harry Charlinsky M. D.
1/30 1913 (Address) Com. Bldg. Corner

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 Edgerton Mo. DATE OF BURIAL Jan. 31, 1913
UNDER-TAKER Carroll Davidson ADDRESS 3024 Troost

Revised United States Standard Certificate of Death

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

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