

Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County McDonald
Township Prarie
or
Village
or
City

Registration District No. 517 File No. 1905
Primary Registration District No. 5689 Registered No. 1
(NO. _____ St.: _____ Ward)

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

FULL NAME Anna Lee Kennedy

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
DATE OF BIRTH Jan. 10, 1913
(Month) (Day) (Year)
AGE 17 yrs. 17 mos. 17 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER Ross C Kennedy
BIRTHPLACE OF FATHER (City or town, State or foreign country) Okla.
MAIDEN NAME OF MOTHER Eva Edwards
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Okla.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ross C Kennedy
(ADDRESS) So. West City

Filed Jan. 28 1913 JO BEASON
REGISTRAR

7. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 27 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 10, 1913, to Jan. 27, 1913, that I last saw her alive on Jan. 24, 1913, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Starvation

34
158
(Duration) yrs. mos. ds.

Contributed to the death by the breast milk
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) John P. Beason M. D.
Jan. 28 1913 (Address) So. West City

*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 City Cemetery DATE OF BURIAL Jan. 28 1913

UNDERTAKER Nichols Bros. ADDRESS So. West City Mo.

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 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.)

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

CERTIFICATE OF DEATH

PLACE OF DEATH
County McDonald
Township Pririe
or
Village
or
City (NO. _____)

Registration District No. 217 File No. _____
Primary Registration District No. 5687 Registered No. 1
St.: _____ Ward) _____

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

FULL NAME Anna Lee Kennedy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)
DATE OF BIRTH <u>Jan. 10, 1913</u> (Month) (Day) (Year)		
AGE <u>17</u> yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant-Invantion</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Mo. Okla.</u>		
PARENTS	NAME OF FATHER <u>Ross C. Kennedy</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Okla.</u>	
	MAIDEN NAME OF MOTHER <u>W. Edmonds</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Okla.</u>	

DATE OF DEATH
Jan. 27, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 10, 1913, to Jan. 27, 1913, that I last saw her alive on Jan. 24, 1913, and that death occurred, on the date stated above, at 6:30 p.m.
The CAUSE OF DEATH* was as follows:
Syphilis

Contributory no breast-milk
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John Pearson M. D.
Jan. 28, 1913 (Address) No. West-City

*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
(Informant) Ross C. Kennedy
(ADDRESS) No. West-City
dated 3/20 1913 J. Pearson REGISTRAR

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
City Cemetery

DATE OF BURIAL
Jan. 28, 1913

UNDERTAKER
Nichols Bros., No. West-City

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified.

THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH

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 "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.)

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