

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

PLACE OF DEATH
County Jackson
Township Kaw
or
Village _____
or
City Kansas City, Mo. (NO South Side Hospital) St. _____ Ward _____

Registration District No. 3997 File No. 19915

Primary Registration District No. 1002 Registered No. 2078

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

FULL NAME Samuel Harpool

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Wh. SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) married
DATE OF BIRTH Oct 24, 1870
(Month) (Day) (Year)

AGE 42 yrs. 8 mos. 6 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Machinist Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Kaw Bakery Co.

BIRTHPLACE (City or town, State or foreign country) Mo. 5-4-5

NAME OF FATHER Henry Harpool

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

MAIDEN NAME OF MOTHER Lillitha Melton

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ann Harpool
(ADDRESS) 1319 Bellefontaine

Filed JUN 30 1913 1913 W.S. Wheeler REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 29, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 22, 1913 to June 28, 1913, that I last saw him alive on June 28, 1913, and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:
Mineritis of cerebellum, to
secondary ethmoid cells

Contributory Polypi (dead bones) on back sides of nose.
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) H. E. Sherman M. D.
June 29, 1913 (Address) 3209 Highland

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

Where was disease contracted if not at place of death?
Former or usual residence 1219 Bellefontaine ave

PLACE OF BURIAL OR REMOVAL Springfield Mo. DATE OF BURIAL May 1, 1913

UNDERTAKER Mrs. C. L. Foster ADDRESS 918 Brooklynn

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.

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 *septicæmia*," "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.)

County Jackson
Township Kaw
Village Kansas City
City Kansas City (NO. South Side Hospital Ward)

Registration District No. 399 File No. _____
Primary Registration District No. 1002 Registered No. 2078

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

FULL NAME

Daniel Harpool

PERSONAL AND STATISTICAL PARTICULARS

SEX Satisfactory Information Supplied.
COLOR OR RACE _____
SINGLE MARRIED, WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____
(Month) _____ (Day) _____ (Year) _____
Satisfactory Information Supplied.

AGE _____
If LESS than 1 day, _____ hrs. _____ min. _____
_____ yrs. _____ mos. _____ ds.

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

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

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____
SUPPLEMENTARY INFORMATION SUPPLIED

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____
Satisfactory Information Supplied.

(ADDRESS) _____

Filed June 30 1913 W.S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 29, 1913
(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____
to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Meningitis secondary to removal
of infected teeth
operations for relief of Polypsi.
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Polypsi (dead bones) on both
sides of nose
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. C. Thomas M. D.
June 29, 1913 (Address) 3209 Highland

*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 _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____
Satisfactory Information Supplied.

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 *septicæmia*," "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.)