

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 (NO. 3202 Penn St., 3 Ward)

Registration District No. 3997 File No. 26609  
Primary Registration District No. 1002 Registered No. 2767

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

FULL NAME Thomas Powers

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	MARRIED OR DIVERCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>June 21, 1846</u> (Month) (Day) (Year)		
AGE <u>67</u> yrs. <u>2</u> mos. <u>2</u> ds. If LESS than 1 day, hrs. or min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Stocks trader</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Live Stock Dealer</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Syracuse, New York</u>		
PARENTS	NAME OF FATHER <u>Wm. C. Graham</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>unknown</u>	
	MAIDEN NAME OF MOTHER <u>unknown Graham</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>unknown</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 23, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 12<sup>th</sup>, 1913, to Aug 23, 1913, that I last saw him alive on Aug 23, 1913, and that death occurred, on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH\* was as follows:  
Acute Gastroenteritis, etc  
Heat Prostration  
12 C.B.  
(Duration) - yrs. - mos. 14 ds.

Contributory Heat Prostration  
(SECONDARY)  
(Duration) - yrs. - mos. 14 ds.

(Signed) Dr. J. R. Kistler M. D.  
Aug 23, 1913 (Address) 1120 Main St. C. Mo

\*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  
South Hill

DATE OF BURIAL  
Aug. 27, 1913

UNDERTAKER  
J. J. Donnell

ADDRESS  
1109 Bdg

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Dr. J. R. Kistler  
(ADDRESS) 1120 Main St. C. Mo  
FILED AUG 25 1913 1913  
W. S. Wheeler  
REGISTRAR

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, 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.)

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.

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CERTIFICATE OF DEATH

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

PLACE OF DEATH Jackson  
 County Kaw Registration District No. 399 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ or \_\_\_\_\_  
 Village \_\_\_\_\_ Primary Registration District No. 1002 Registered No. 2767  
 City Kansas City No. 3203 St. 3 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 FULL NAME Thomas Powers

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE married  
 MARRIED WIDOWED OR DIVORCED (Write the word)  
 DATE OF BIRTH \_\_\_\_\_; 1 (Day) (Year)  
 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. if LESS than \_\_\_\_\_ day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 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 unknown  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown  
 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Dr. Joe. Kuttler  
 (ADDRESS) 1120 Main, K. C. Mo  
 Filed Aug 25 1913 W.S. Wheeler  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 23, 1913  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, 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:  
 \_\_\_\_\_  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory \_\_\_\_\_ (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ M. D.  
 \_\_\_\_\_, 191\_\_\_\_ (Address)  
 \*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 \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 \_\_\_\_\_

Satisfactory Information Supplied

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