

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

PLACE OF DEATH
County Jackson
Township _____
or
Village _____
or
City Kansas City (NO. 1825 Main St Ward _____)

Registration District No. 399 File No. 4866
Primary Registration District No. 1002 Registered No. 515

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

FULL NAME George Todd

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>Black</u>	SINGLE MARRIED WIDDED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Feb</u> <u>8</u> , 19 <u>28</u> (Month) (Day) (Year)		
AGE <u>36</u> yrs. <u>5</u> mos. <u>5</u> ds. IF LESS than 1 day, ___ hrs or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Labor</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Day labor</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Fayette Mo</u>		
PARENTS	NAME OF FATHER <u>John Hill</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Fayette Mo</u>	
	MAIDEN NAME OF MOTHER <u>Jane Todd</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Fayette Mo</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Todd
(ADDRESS) 1825 Main St

FEB 14 1914
Filed _____ 191____ W.S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 13, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 9, 1914 to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis
23A
194B (Duration) _____ yrs. _____ mos. _____ ds.
Contributory Exposure
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

Signed E. W. Brown M. D.
2-14, 1914 (Address) 805 Independence

*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 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 <u>Kansas City Kansas</u>	DATE OF BURIAL <u>Feb 15</u> , 19 <u>14</u>
UNDERTAKER <u>People Undertaking Co.</u>	ADDRESS <u>1211 E 18th</u>

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 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 is very important.

PLACE OF DEATH

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

County Jackson

Township _____

Village _____

City Kansas City

Registration District No. 399

File No. _____

Primary Registration District No. 1002

Registered No. _____

St. _____ Ward _____

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

FULL NAME George Todd

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OF RACE B SINGLE MARRIED WIDOWED OR DIVORCED Single

DATE OF DEATH Feb. 13, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____
(Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____,

AGE _____ yrs. _____ mos. _____ ds. IF LESS than _____ hrs. _____ min.

and that death occurred, on the _____ stated above, at _____ m. The CAUSE OF DEATH* was as follows:

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

Acute Tuberculosis Pulmonary
(Duration) _____ yrs. _____ mos. _____ ds.

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

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

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) _____

(Signed) L. M. Brown M. D.
2-14-14 (Address) 800 Indef. Ave.

*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. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

(Informant) _____ (ADDRESS) _____

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

Former or usual residence _____

Filed X _____, 191____ M. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____

FEB - 1914

Revised United States Standard Certificate of Death

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

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