

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. 3001 Wyandotte)

Registration District No. 399 File No. 22719
Primary Registration District No. 1002 Registered No. 2125
St. _____ Ward _____

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

FULL NAME Mrs. Anna Carlson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White ~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ Married
(Write the word)
DATE OF BIRTH July 19, 1853
(Month) (Day) (Year)
AGE 51 yrs. 11 mos. 25 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) None

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

PARENTS
NAME OF FATHER David Johnson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweden
MAIDEN NAME OF MOTHER Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sweden

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. C. A. Carlson
(ADDRESS) Smolan Kan
JUL 19 1914
Filed _____ 191____ W. S. Wheeler
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 28, 1914, to July 12, 1914, that I last saw h. or alive on July 11, 1914, and that death occurred, on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Adenocarcinoma of bowel + mesentery
46 C
46 G (Duration) 2 yrs. _____ mos. _____ ds.
Contributory Shock
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

Signed J. H. Roberts M. D.
July 12, 1914 (Address) 1105 Realto Bldg.

*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 no yrs. no mos. 24 ds. In the State no yrs. no mos. 24 ds.
Where was disease contracted if not at place of death? Smolan Kan
Former or usual residence Smolan Kan

PLACE OF BURIAL OR REMOVAL Smolan Kan DATE OF BURIAL July 13, 1914
UNDERTAKER W. P. Doehler ADDRESS 1403 East 15th

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.)

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

PLACE OF DEATH

County Jackson

Township _____

or

Village _____

or

City Kansas City (NO. 3011 Wyandotte St.; _____ Ward)

Registration District No. 399

File No. _____

Primary Registration District No. 1002

Registered No. 2125-

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

FULL NAME Mrs. Anna Carlsson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX ♀ COLOR OR RACE W. SINGLE MARRIED M WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH July 12, 1914
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____ 1914
that I last saw live on _____, 1914
Satisfactory Information Supplied

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

and that death occurred, on the date 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) _____

Coronary of heart
to Mesenteric
Shock was cause of death.

BIRTHPLACE (City or town, State or foreign country) _____
Satisfactory Information Supplied

(Duration) 2 yrs. X mos. _____ ds.

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) _____

Contributory Shock
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. Roberts M. D.
July 12, 1914 (Address) 1105 Reata Pl.

*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) Satisfactory Information Supplied

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
If not at place of death? _____

(ADDRESS) _____

Former or usual residence _____

Filed X _____ 1914 M. S. Wheel
REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____
UNDERTAKER Satisfactory Information Supplied 1914
ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. FILED, F. A. G. E. should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be stated EXACTLY.

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

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