

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

PLACE OF DEATH
County Jackson
Township Kear Registration District No. 399 File No. 22741
or Village _____ Primary Registration District No. 1002 Registered No. 2147
or City Kansas City Mo. (NO. German Harp St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Eleanor M. Rowland

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)
DATE OF BIRTH Feb 4, 1914
(Month) (Day) (Year)

AGE 6 yrs. 10 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

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

PARENTS
NAME OF FATHER C. B. Rowland
BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri
MAIDEN NAME OF MOTHER Hellie Heffron
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. B. Rowland
(ADDRESS) 4001 Olive

JUL 14 1914
Filed _____ 1914 M. S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 14, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 10, 1914, to July 14, 1914, that I last saw her alive on July 13, 1914, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:
Intussusception

1228
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Frank S. Duff M. D.
July 14, 1914 (Address) 200 Olive

*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 St. Marys DATE OF BURIAL July 15, 1914
UNDERTAKER John H. Wagner ADDRESS 1429 Grand

N. B.—Every item of information should be carefully supplied. AGE should be so or so EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. FACTS as to 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.)

Dr. K. J. ...
George ...

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PLACE OF DEATH

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

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

County Jackson Registration District No. 999 File No. _____
 Township _____ or Village _____ Primary Registration District No. 1002 Registered No. 2147
 City Kansas City (NO. German / Corp. St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Eleanor M. Rowland

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH July 14, 1914
(Month) (Day) (Year)

DATE OF BIRTH Satisfactory Information Supplied.
(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.

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

The CAUSE OF DEATH* was as follows:
Entussureception
189 X
(Duration) 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) _____

Contributory (SECONDARY) _____ (Duration) yrs. mos. 5 ds.
 (Signed) Frank C. Kelly M. D. July 14 1914 (Address) 900 Kault

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

*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. 13 ds. In the State of _____
 Where was disease contracted _____
 If not at place of death? _____
 Former or usual residence _____

(ADDRESS) _____
 Filed X 1914 M.S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDER _____ ADDRESS Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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