

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

PLACE OF DEATH
County Jackson
Township Haw or Village _____
City Kansas City (NO. General Hospital St. _____ Ward _____)
Registration District No. 399 File No. 22827
Primary Registration District No. 1002 Registered No. 2233

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

FULL NAME Fred Gray

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH July 17 1914
(Month) (Day) (Year)

DATE OF BIRTH Not Known
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from As corpse, 191 , to , 191 , that I last saw h alive on , 191 , and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:

AGE About 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

Multiple Inguinal Burns by Gas
181 (Duration) yrs. mos. ds.
Contributory (Secondary) (Duration) yrs. mos. ds.

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

BIRTHPLACE (City or town, State or foreign country) Not Known

NAME OF FATHER Not Known

BIRTHPLACE OF FATHER (City or town, State or foreign country) Not Known

MAIDEN NAME OF MOTHER Not Known

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not Known

(Signed) Fritz W. Manning M. D.
7-18-1914 (Address) KANSAS CITY, 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 Not Known In the Not Known State yrs. mos. ds.

Where was disease contracted if not at place of death?
Former or usual residence Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. R. Miller

PLACE OF BURIAL OR REMOVAL Union Cemetery DATE OF BURIAL July 22 1914

(ADDRESS) 2015 Main St.

UNDERTAKER Quirk & Tobin ADDRESS 3015 Main

JUL 22 1914
Filed _____ 191 M. 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*, *Composer*, *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.)

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

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

PLACE OF DEATH

County Jackson
Township _____
or
Village _____
or
City Kansas City (NO. _____ St.; _____ Ward)

Registration District No. 399 File No. _____
Primary Registration District No. 1000 Registered No. 2293

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

FULL NAME

Fred Gray

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M.</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Satisfactory Information Supplied</u> , 191 <u>1</u> (Year)		
AGE _____ yrs. _____ mos. _____ ds.		IF LESS than 1 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) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 17, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied, 1911, that I last saw him alive on _____, 1911, and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:
Multiple Burns by fire accidental X 1/16

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

SUPPLEMENTARY Satisfactory Information Supplied.

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. _____ ds.

(Signed) Dr. J. McLaughlin M. D. 7-18-11 (Address) Kansas City, Mo.

*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 Satisfactory Information Supplied ds.
Where was disease contracted If not at place of death? _____

Former or usual residence _____

(ADDRESS) _____
Filed X 1911 W. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL _____	DATE OF BURIAL _____ 191 <u>1</u>
UNDERTAKE <u>Satisfactory Information Supplied</u>	Address _____

Revised United States Standard Certificate of Death

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

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