

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Jackson
Township Kan
or
Village
or
City Kansas City Mo (NO. Swedish Hosp St. Ward)

Registration District No. 899 File No. 29390
Primary Registration District No. 1002 Registered No. 2898

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

FULL NAME Mrs Bertha Held

PERSONAL AND STATISTICAL PARTICULARS

4 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
DATE OF BIRTH Oct 20, 1840
(Month) (Day) (Year)
AGE 73 yrs. 11 mos. 30 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Sept 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 21, 1914, to Sept 21, 1914, that I last saw her alive on Sept 21, 1914, and that death occurred, on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

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

General Venereal Disease
Stroke
12 1/2 yrs
4 1/2 mos (Duration) ___ yrs. ___ mos. 3 ds.
Contributory acute obstruction ileum
(SECONDARY) (Duration) ___ yrs. ___ mos. 4 ds.

BIRTHPLACE (City or town, State or foreign country) Germany
PARENTS
NAME OF FATHER Jacob Held
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Bertha Anderson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

(Signed) J. P. K... M. D.
9/22/14 (Address) 1025 Route

*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. 3 ds. In the 50 State ___ yrs. ___ mos. ___ ds.
Where was disease contracted If not at place of death?
Former or usual residence Randolph, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Harry Stephens
(ADDRESS) Randolph Mo

PLACE OF BURIAL OR REMOVAL Randolph Mo DATE OF BURIAL Sept 24, 1914
UNDERTAKER John W Wagner ADDRESS 1409 Grand ave

Filed SEP 23 1914 REGISTRAR R. S. Medel

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.)

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES 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. 1002 Registered No. 2898

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

FULL NAME Bartha Held

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, _____, 19____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.
If LESS than _____ day(s) _____ hr(s) _____ min(s)

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

(ADDRESS) _____
File # _____ 19____
W. S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
STRANGULATED INTERNAL HERNIA
Gen. Peritonitis
Shock.
(Duration) 5 days mos. _____ ds. _____

Contributory acute obstruction
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. _____
(Signed) J. S. Fulmer M. D.
9/22 1914 (Address) 1025 Rialto

*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 _____ yrs. _____ mos. _____ ds. 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 _____ 19____
UNDERTAKER _____ ADDRESS Supplied

SUPPLEMENTARY INFORMATION SUPPLIED

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY UNDERSTOOD BY THE GENERAL PUBLIC.

Revised United States Standard Certificate of Death

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

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29390

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