

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

1 PLACE OF DEATH

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

Registration District No. 399

File No. 11

4926

Primary Registration District No. 1002

Registered No. 643

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

2 FULL NAME Eli B. Hunter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Jan (Mik.) 1855
(Month) (Day) (Year)

7 AGE 60 yrs. 1 mos. ds. If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Pa.

PARENTS 10 NAME OF FATHER Don't know
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know
12 MAIDEN NAME OF MOTHER Don't know
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Lauren A. Hunter
(Address) 1140 Pa. St.

15 FEB 21 1915 Filed _____ 1915 M.S. Wheeler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 21st 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 2-18-1915 to 2-21-1915, that I last saw him alive on 2-21-1915, and that death occurred, on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:
Uremia
127 A
130
127 B (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) operation for double incarcerated hernia
(Duration) yrs. mos. ds. (Signed) John H. Leonard M. D. 2-21-1915 (Address) 1075 Rialto Bldg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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 Baumana, Kas.

19 PLACE OF BURIAL OR REMOVAL Baumana, Kas. DATE OF BURIAL 2/21/1915

20 UNDERTAKER Thos. & Marshall ADDRESS 3146 Main St.

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.)

PLACE OF DEATH

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

County _____

Township _____

or _____

Village _____

or _____

City Kansas city (NO. _____ St.: _____ Ward)Registration District No. 399 File No. _____Primary Registration District No. 1002 Registered No. 643
 [If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number]
FULL NAME Eli. B. Hunter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MCOLOR OR RACE WSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) MDATE OF DEATH Feb 21, 1919

(Month)

(Day)

(Year)

DATE OF BIRTH _____

(Month)

(Day)

(Year)

AGE _____

yrs. mos. ds.

If LESS than
1 day, hrs.
or mins.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 2:15 p.m.The CAUSE OF DEATH* was as follows:
Uraemia Acute HepatitisOCCUPATION
(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) _____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) _____

Filed 2/21, 1919 W.S. Wheeler

REGISTRAR

Contributory Operation for double

(SECONDARY)

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

(Signed) John H. Rutland M.D.1/20, 1919 (Address) 1625 Rialto Blvd

*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 _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

Original file, date _____, 19____

All information called for must be written on this Supplementary Certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

 SUPPLEMENTARY
 Satisfactory Information supplied

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