

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Johnson
Township
or
Village
or
City Warrensburg (NO. St.: Ward)

Registration District No. 431 File No.
Primary Registration District No. 3023 Registered No. 965173

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

2 FULL NAME Mrs. Harriet Huff

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|--|--|
| 3 SEX <u>f</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Widow</u> (Write the word) |
| 6 DATE OF BIRTH <u>unknown</u> 18 <u>23</u> (Month) (Day) (Year) | | |
| 7 AGE <u>92</u> yrs. mos. ds. | If LESS than 1 day, hrs. min.? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>At Home</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>none</u> | | |
| 9 BIRTHPLACE (City or town, State or foreign country) <u>Kentucky</u> | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | |
| | 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>Julia S. Nelson</u> | |
| | 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky.</u> | |

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 7th 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Occasionally 1915
that I last saw h. u alive on Feb 7 1915
and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Apoplexy
162
Long Standing
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age
(Duration) yrs. mos. ds.

(Signed) Chas. Lewis M. D.
Feb 9th 1915 (Address) Warrensburg Mo.

*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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Kusport
(Address) Kansas City 1914 Pasco Ave.

15 Filed Feb 10 1915 D. C. Adams
Registrar

19 PLACE OF BURIAL OR REMOVAL City Cemetery DATE OF BURIAL Feb 9 1915
20 UNDERTAKER J. M. McMeekin ADDRESS City

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 CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County Johnson

Township _____

Village _____

City Warrensburg (NO. _____)

Registration District No. 431

Primary Registration District No. 3023

File No. _____

Registered No. 9

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

FULL NAME

Harriet Huff

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OF RACE B SINGLE MARRIED WIDOWED OR DIVORCED W

DATE OF DEATH _____, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 191
(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 _____.

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

The CAUSE OF DEATH was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work _____

Chronic Nephritis

(b) General nature of industry, business, or establishment in which employed, (or employer) _____

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

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

NAME OF FATHER _____

Contributory old age
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

(Signed) _____ M. D.

MAIDEN NAME OF MOTHER _____

(Address) Warrensburg, Mo.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

*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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) _____

At place of death same yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) _____

Where was disease contracted If not at place of death? _____

Filed _____ 1915

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191

UNDERTAKER _____ ADDRESS _____

REGISTRAR

Every item of information should state CAUSE OF DEATH in plain terms. If not statement of OCCUPATION is very important.

Supplementary Information supplied by _____

Supplementary Information supplied by _____

Revised United States Standard Certificate of Death

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