

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

1 PLACE OF DEATH

County Little Sisters of the Poor Jackson
Township Nash Registration District No. 399 File No. 8490
or Village 318 Gillham Primary Registration District No. 1002 Registered No. 763
or City Kansas City, Mo. (NO. Home aged St. _____ Ward _____)

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

2 FULL NAME Sister Angèle de Ste Marie
Noelle Miller

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH March 1 1830
(Month) (Day) (Year)
7 AGE 85 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

16 DATE OF DEATH March 1 st 1915
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from 26th Feb 1915 to March 1st 1915, that I last saw her alive on March 1st 1915, and that death occurred, on the date stated above, at 10 P. m.

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

The CAUSE OF DEATH* was as follows:
108
162 Pneumonia
(Duration) _____ yrs. _____ mos. 3 ds.

9 BIRTHPLACE (City or town, State or foreign country) Chambery France

CONTRIBUTORY (Secondary) Exhaustion
(Duration) _____ yrs. _____ mos. 1 ds.
(Signed) J. Keonigan M. D.
March 1915 (Address) 1107 E 53rd

PARENTS
10 NAME OF FATHER Georges Million
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) France
12 MAIDEN NAME OF MOTHER Claudine Domein
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) France

*State the Disease Causing Death, or, in death 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 33 yrs. _____ mos. _____ ds. In the State 33 yrs. _____ mos. _____ ds.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) St. Frances Sup
(Address) 318 Gillham

Where was disease contracted if not at place of death? at Place of Death
Former or usual residence France

15 MAR - 2 1915 Little Sisters of the Poor
Filed _____ 1915 W. S. Wheeler
Registrar

19 PLACE OF BURIAL OR REMOVAL Mt. St. Mary's DATE OF BURIAL Mar - 3 1915
20 UNDERTAKER J. C. Wuffie ADDRESS 3020 Balt. ave.

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.)

PLACE OF DEATH

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

CERTIFICATE OF DEATH

County _____ Township _____ or Village _____ or City Kansas City (No. None of aged St. _____ Ward _____)

Registration District No. 399 File No. _____

Primary Registration District No. 1002 Registered No. 763

FULL NAME Sister Angèle Ste Marie

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF BIRTH _____ (Month) _____ (Day) _____ (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) _____

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) _____

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

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.

THE CAUSE OF DEATH* was as follows:
Lobar Pneumonia

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

(Signed) J. A. Horner M. D. 3/20 1915 (Address) 4107 E 53rd

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed 3/2 1915 W.S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms at it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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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

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