

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

PLACE OF DEATH:

County: Jackson

Township: Raw

Village: \_\_\_\_\_

City: Kansas City (NO. 2117A) East 15<sup>th</sup> St.; \_\_\_\_\_ Ward)

Registration District No. 399

File No. 8500

Primary Registration District No. 1002

Registered No. 773

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

FULL NAME: May E. Morrison

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX: Female COLOR OR RACE: White SINGLE MARRIED WIDOWED OR DIVORCED: Divorced (If wife, the word)

DATE OF DEATH: Feb. 28, 1915  
(Month) (Day) (Year)

DATE OF BIRTH: May 15, 1879  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 22, 1915, to Feb 28, 1915, that I last saw her alive on Feb 28, 1916, and that death occurred, on the date stated above, at 7 P.m.

AGE: 35 yrs. 9 mos. 13 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Septicemia, from wound of fish bone in esophagus

OCCUPATION (a) Trade, profession, or particular kind of work: Clerk Porter & Curtain Department, Keith  
(b) General nature of industry, business, or establishment in which employed (or employer): \_\_\_\_\_

107H (Duration) yrs. \_\_\_ mos. \_\_\_ ds.  
Contributory: Secondary pneumonia (SECONDARY) (Duration) yrs. \_\_\_ mos. 3 ds.

BIRTHPLACE (City or town, State or foreign country): Iowa

NAME OF FATHER: Walter S. Marchant

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

MAIDEN NAME OF MOTHER: Sarah Hudlow

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

(Signed) Geo A. Droll M. D.  
Mar. 1, 1915 (Address) 2301-E, 14

\*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): Walter S. Marchant

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: \_\_\_\_\_

(ADDRESS) National Home

PLACE OF BURIAL OR REMOVAL: Elmwood DATE OF BURIAL: Mar 3<sup>rd</sup>, 1915  
UNDERTAKER: Thise & Cassady ADDRESS: 2202 E. 15<sup>th</sup>

MAR -3 1915 Filed \_\_\_\_\_ 1915 W. S. Wheeler REGISTRAR

Every item of information furnished is subject to audit. 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

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

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

County \_\_\_\_\_

Township \_\_\_\_\_

or  
Village \_\_\_\_\_City Kansas City (NO. 31170 East 15<sup>th</sup> St.: \_\_\_\_\_ Ward)Registration District No. 399

File No. \_\_\_\_\_

Primary Registration District No. 1003Registered No. 773

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

FULL NAME May E. Morrison

## PERSONAL AND STATISTICAL PARTICULARS

SEX 91 COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED 20  
(If write the word)

DATE OF BIRTH \_\_\_\_\_, 19\_\_\_\_  
(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) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed 3/3 19151915W. S. Wheeler

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Septicemia from wound of fish bone in esophagus

Contributor Bronchitis  
(SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributor Secondary Pneumonia  
(SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

(Signed) Geo A. Droll M. D.  
311 \_\_\_\_\_, 1915 (Address) 3301 E 14<sup>th</sup>

\*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 \_\_\_\_\_, 19\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

Original file, date \_\_\_\_\_, 19\_\_\_\_

19\_\_\_\_

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

CAUSE OF DEATH information should be carefully supplied. AGE should be carefully supplied. If arms, so that it may be properly preserved.

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
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H.P.B. O.K.