

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

1 PLACE OF DEATH  
County *Jackson*  
Township *Faw*  
or  
Village  
or  
City *Kansas City* (No. *3414 Smart* St.: Ward)

Registration District No. *399* File No. *8553*  
Primary Registration District No. *1002* Registered No. *826*

2 FULL NAME *Thomas Freeman*

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

6 DATE OF BIRTH *Nov 1 1915*  
(Month) (Day) (Year)

7 AGE *78* yrs. mos. ds. If LESS than 1 day, hrs. or min.?  
16 DATE OF DEATH *Mar 6 1915*  
(Month) (Day) (Year)

8 OCCUPATION (a) Trade, profession, or particular kind of work *Retired*  
(b) General nature of industry business, or establishment in which employed (or employer) *Farmer*

17 I HEREBY CERTIFY, that I attended deceased from *Feb 19 1915* to *March 6 1915*, that I last saw him alive on *March 5 1915*, and that death occurred, on the date stated above, at *1:30 a.m.*

9 BIRTHPLACE (City or town, State or foreign country) *Ireland*

The CAUSE OF DEATH\* was as follows:  
*Combined Degeneration of the Brain and heart*  
*89B*  
*16 2* (Duration) *2* yrs. - mos. - ds.

10 NAME OF FATHER *Wm. Know*

CONTRIBUTORY (Secondary) *John H. Lapp* (Duration) yrs. mos. ds. (Signed) *John H. Lapp* M. D. (Address) *1924 Rialto*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Wm. Know*

12 MAIDEN NAME OF MOTHER *Wm. Know*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Wm. Know*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Informant) *Edw. B. Phemister*

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

(Address) *3414 Smart ave.*

15 Filed *MAR -7 1915* *W.S. Wheeler* Registrar

19 PLACE OF BURIAL OR REMOVAL *St Marys* DATE OF BURIAL *3/8 1915*

20 UNDERTAKER *J.F. O'Connell & Co* ADDRESS *1109 Brady*

N. B.—Every death certificate 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; a void

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 septichaemia," "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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City Kansas City  
 Registration District No. 399 File No. \_\_\_\_\_  
 Primary Registration District No. 1002 Registered No. 826  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Thomas Franman

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

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

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\_\_\_\_\_,

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

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_\_, and that death occurred, on the date stated above, at 130 min.

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

The CAUSE OF DEATH\* was as follows:

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

Combined degeneration of the brain and cord

NAME OF FATHER \_\_\_\_\_

(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Contributory Senility (Secondary) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

MAIDEN NAME OF MOTHER \_\_\_\_\_

(Signed) John G. Dahr M. D. 317 1915 (Address) 724 Rialto

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 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Where was disease contracted If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

Filed 3/7 1915

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

REGISTRAR \_\_\_\_\_

Original file, date \_\_\_\_\_, 19\_\_\_\_. All information called for must be written on this Supplementary Certificate.

N. B. - Examine carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state, but 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  
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