

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

PLACE OF DEATH  
County Jackson  
Township Kan Registration District No. 399 File No. 8589  
or Village Kansas City Primary Registration District No. 1002 Registered No. 862  
or City Kansas City (NO. Old Genl Hosp a Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Robt. Jordan

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

SEX M COLOR OR RACE Col SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)  
DATE OF BIRTH Jan 3 1885  
(Month) (Day) (Year)

DATE OF DEATH Mar 4 1915  
(Month) (Day) (Year)

AGE 30 yrs. 1 mos. 1 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

HEREBY CERTIFY, that I attended deceased from Feb 12, 1915, to 3-4, 1915, that I last saw him alive on 3-4, 1915, and that death occurred, on the date stated above, at 7:50 p.m.

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

The CAUSE OF DEATH\* was as follows:  
Traumatic Pneumonia

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

Contributory Sunshot of lungs  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

PARENTS  
NAME OF FATHER Robert Jordan  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee  
MAIDEN NAME OF MOTHER Rebecca Cifers  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

(Signed) M. Williams M. D.  
3-5, 1915 (Address) Old Genl. Hospital

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mary Nelson  
(ADDRESS) KANSAS CITY, MO.

\*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. 29 ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted If not at place of death? do not know  
Former or usual residence 039 E 4

Filed MAR 10 1915 191 W. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL Grindlaw DATE OF BURIAL Mar 10 1915  
UNDERTAKER Watkins Bros ADDRESS 1729 Sycia

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, meningis, 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

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City Kansas City

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 DEATHRegistration District No. 399

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

Primary Registration District No. 1002Registered No. 862NO. Old Gul Hosp

St. \_\_\_\_\_

Ward) \_\_\_\_\_

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

FULL NAME Robt Jordan

## PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE B SINGLE S  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)DATE OF BIRTH \_\_\_\_\_  
(Month) (Day) (Year) 1AGE \_\_\_\_\_  
If LESS than  
1 day, \_\_\_\_\_ hrs  
or \_\_\_\_\_ min  
\_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.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 3/10 1915 W.S. Wheeler

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH MAY 4, 1915  
(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 75 m.The CAUSE OF DEATH\* was as follows:  
PneumoniaContributory Gun shot of lungs  
(Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.  
(Signed) Wm J. L... M.D.  
375 1915 (Address) Old Gul Hosp

\*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 \_\_\_\_\_

MAR 1915

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

# Revised United States Standard Certificate of Death

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

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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.)

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