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

1 PLACE OF DEATH

County Jackson

Township or Village or City Kansas City (NO 2405 Denver St.; Ward)

Registration District No. 399 File No. 8738

Primary Registration District No. 1002 Registered No. 1010

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

2 FULL NAME Eunice Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Feb (Month) 8 (Day) 1845 (Year)

7 AGE 70 yrs. 1 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Canada

PARENTS

10 NAME OF FATHER John Lane

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mr Kinnon

12 MAIDEN NAME OF MOTHER —

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Prosdue

(Address) 2405 Denver

15 Filed MAR 20 1915, 191 W. S. Wheeler Registrar

MEDICAL CERTIFICATE OF DEATH

3

16 DATE OF DEATH March (Month) 19 (Day), 1915 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar. 15, 1915, to Mar. 19, 1915, that I last saw her alive on Mar. 19, 1915, and that death occurred, on the date stated above, at 845 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (Apoplexy) 64

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Accidental injury

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Jno. M. Waeden M. D.

Mar. 19 1915 (Address) 508-9 Grand Av. Temple

*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

19 PLACE OF BURIAL OR REMOVAL Saginaw Michigan

DATE OF BURIAL Mar 24 1915

20 UNDERTAKER Mrs. C. L. Forster

ADDRESS 918 Brooklyn

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 *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.)

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

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City Kansas City (NO. _____ St.: _____ Ward)

Registration District No. 399 File No. _____

Primary Registration District No. 1002 Registered No. 1010

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

FULL NAME Eunice Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) W

DATE OF BIRTH _____ (Month) _____ (Day) _____, 1 (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 3/20, 1915. W. S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mch 19, 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 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (apoplexy)

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (SECONDARY) Accidental Injury

Fell off back porch (Duration) _____ yrs. _____ mos. 5 ds.

(Signed) _____ M. D.

3/19, 1915 (Address) _____

*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

SUPPLEMENTARY

172

Original file, date _____, 19__

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state [illegible] Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

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

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