

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

PLACE OF DEATH

County Jackson
Township Law
or
Village _____
or
City Kansas City Mo. (NO. 2801 Jackson St., _____ Ward)

Registration District No. 399 File No. 8768

Primary Registration District No. 1002 Registered No. 1040

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

FULL NAME Mrs. Charlotte Ellsasser

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White CHOOSE MARRIED UNMARRIED OR DIVORCED (Write the word) Married
DATE OF BIRTH May 20 1856
(Month) (Day) (Year)
AGE 48 yrs. 10 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) George Town Ken

PARENTS
NAME OF FATHER Reason Howard
BIRTHPLACE OF FATHER (City or town, State or foreign country) Geo. Town Ken
MAIDEN NAME OF MOTHER Alice Barnett
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. John Ellsasser
(ADDRESS) 2801 Jackson

Filed MAR 23 1915 W. S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 22 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 20, 1915, to Mar 20, 1915, that I last saw her alive on Mar 20, 1915, and that death occurred, on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

Contributory Nephritis
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) S. J. Jones M. D.
3-23 1915 (Address) 6513 C

*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 Linwood Cem. DATE OF BURIAL March 24 1915

UNDERTAKER A. P. Doehler ADDRESS 1403 East 15th St.

CAUSE OF DEATH in plain language 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.)

WHILE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY in years, months, and days, so that it may be properly classified. Penicillin should be stated.

PLACE OF DEATH *m353*

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 _____ Registration District No. *399* File No. _____
Township _____ or _____ Village _____ or _____ City _____ (No. _____ St. _____ Ward _____)

Primary Registration District No. *1002* Registered No. *1040*

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

FULL NAME *Harold Ellsworth*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 191*5*
(Month) (Day) (Year)

DATE OF BIRTH _____, 191*5*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191*5*, to _____, 191*5*, that I last saw h. _____ alive on _____, 191*5*, and that death occurred, on the date stated above, at *9 P* m.

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:

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

Valvular Les Heart

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

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

NAME OF FATHER _____

Contributor (SECONDARY) *Primordial White*

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

(Duration) _____ yrs. _____ mos. _____ ds. (Address) *573 Commerce*

MAIDEN NAME OF MOTHER _____

(Date) *3/23* 191*5* (Address) *573 Commerce*

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) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(Informant) _____

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

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191*5*

Filed *3/23* 191*5* *H.S. Wheeler* REGISTRAR

UNDERTAKER _____ ADDRESS _____

MAR 1915

Original file, date _____ 191*5* All information 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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