

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

1 PLACE OF DEATH

County Jackson
Township Kaw
Village Kansas City
City Kansas City

Registration District No. 999 File No. 8816
Primary Registration District No. 1002 Registered No. 1088
(NO. General Hospital (St. Ward))

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

2 FULL NAME Frank B. Tasiel

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH August 16, 1890
(Month) (Day) (Year)

7 AGE 24 yrs. 6 mos. 29 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS
10 NAME OF FATHER Frank Tasiel
11 BIRTHPLACE OF FATHER Russia
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER Helen Philips
13 BIRTHPLACE OF MOTHER Germany
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Kretz, Record Clerk
(Address) General Hospital

15 W. S. Wheller
Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 1, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 11, 1915 to March 1, 1915, that I last saw him alive on March 1, 1915, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:
Post-operative Shock

110H
156B (Duration) yrs. mos. ds.

CONTRIBUTORY Empyema - (Rt pleura)
(Secondary) (Duration) yrs. mos. 20(?) ds.
(Signed) Sambhinder M. D.
3-2 1915 (Address) Gen'l Hospital

*State the Disease Causing Death, or, in death 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. 18 ds. In the State yrs. 6 mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence 521 Main

19 PLACE OF BURIAL OR REMOVAL K C Dental College DATE OF BURIAL March 1, 1915

20 UNDERTAKER C. G. Thayer ADDRESS 25 Helms

Anatomical Society - F. B. Rogers Secy

Filed MAR 26 1915

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, Composer, 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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CERTIFICATE OF DEATH

County _____

Township _____ Registration District No. 399 File No. _____
 or _____
 Village _____ Primary Registration District No. 1012 Registered No. 1088
 or _____
 City _____ NO. _____ St. _____ Ward _____

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

FULL NAME Frank B. Kasid Wasil

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> (Write the word)
DATE OF BIRTH _____ (Month) (Day) (Year)		AGE _____ 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) _____		IF LESS than 1 day, _____ hrs. or _____ min. _____

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

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 3/26 1915 W. S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 1, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1915, to _____, 1915, that I last saw h. _____ alive on _____, 1915, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:
Post-operative shock
from resection

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

Contributory Empyema of pleura
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Sam H Spader M. D.
3/2 1915 (Address) Full St. Kas

*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 _____ 1915

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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