

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County Jackson
Township Kaw
or
Village
or
City Kansas City

Registration District No. 899 File No. 8820

Primary Registration District No. 1002 Registered No. 1092

(NO. St Mary Hospital St. Ward)

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

FULL NAME Mary A Conaughton

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)

DATE OF DEATH March 27, 1915
(Month) (Day) (Year)

DATE OF BIRTH Unknown
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 22, 1915, to Mar 27, 1915

AGE About 75 yrs. - mos. - ds. If LESS than 1 day, ___ hrs. or ___ min.?

that I last saw h. — alive on Feb 26, 1915

and that death occurred, on the date stated above, at 6:30 am.

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

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
131
130
132 (Duration) ___ yrs. ___ mos. 10 ds.

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

Contributory Artemia
(SECONDARY) (Duration) ___ yrs. ___ mos. 2 ds.

PARENTS NAME OF FATHER Don't know

(Signed) B. J. Thump M. D.
3/27, 1915 (Address) 1104 Parkview

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

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

MAIDEN NAME OF MOTHER Don't know

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

At place of death ___ yrs. ___ mos. 6 ds. In the 14 yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? K.C. 7720.

(Informant) Georgie Fitzgier

Former or usual residence K.C. 7720.

(ADDRESS) 704 1/2 Charlotte

PLACE OF BURIAL OR REMOVAL St Mary Cemetery DATE OF BURIAL 3/28, 1915

Filed MAR 25 1915

REGISTRAR W.S. Wheeler

REGISTRAR

UNDERTAKER A. W. Wagner ADDRESS 1409 Grand ave.

Should be stated EXACTLY. PH. 111. Exact statement of OCCUPATION.

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, 8 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

County _____
 Township _____ or _____
 Village _____ or _____
 City _____ (No. _____ St. _____ Ward _____)
 Registration District No. 399 File No. _____
 Primary Registration District No. 1003 Registered No. 1092

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

FULL NAME

May A. Conington

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
DATE OF BIRTH _____, _____, _____ (Month) (Day) (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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, _____, 191____
(Month) (Day) (Year)

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 _____.

The CAUSE OF DEATH* was as follows:
chronic nephritis
150

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

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

(Signed) B. Sharp M. D.
3/27 1915 (Address) 111 Realto

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed 3/28 1915 W. S. Wheeler
 REGISTRAR

PLACE OF BURIAL OR REMOVAL _____	DATE OF BURIAL _____ 191____
UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

N. B.—Every item of information should be carefully checked. AGENTS should state the CAUSE OF DEATH in plain terms, so that it may be clearly understood. Exact statement of OCCUPATION should be given. Physicians should state the date of last examination. Exact statement of OCCUPATION should be given. Physicians should state the date of last examination.

Revised United States Standard Certificate of Death

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

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