

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.

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

1 PLACE OF DEATH
County Jackson
Township Raw
Village Kansas City
City Kansas City (NO Tuberculosis Dept.)
Registration District No. 399
Primary Registration District No. 1002
File No. 34500
Registered No. 3000
2 FULL NAME Pat Lyons
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH UNKNOWN
(Month) (Day) (Year)

7 AGE about 48
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS

10 NAME OF FATHER UNKNOWN

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

12 MAIDEN NAME OF MOTHER UNKNOWN

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara J. Crowe
(Address) Tuberculosis Dept

15 DCT 25 1916
Filed. 191 Thos. J. Miller
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 24 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 9-15-1916, to 10-24-1916, that I last saw him alive on 10-23-1916, and that death occurred, on the date stated above, at 4:49 am.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
near
28
(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) Dr. S. B. Nischberg, M. D.
10-24-1916 (Address) T. B. Dept. Ave. Crowe

*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. 1 mos. 10 ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death? Home
Former or usual residence 204 Main St. N. C. Mo.

19 PLACE OF BURIAL OR REMOVAL St. Mary's DATE OF BURIAL 10/26 1916

20 UNDERTAKER Queen of Peace Co ADDRESS 204 Main St. N. C. Mo.

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*.

worked on may form part of the second never return "Laborer," "Foreman," "Dealer," etc., without more precise as *Day laborer*, *Farm laborer*, *Laborer*—

b. Women at home, who are engaged of the household only (not paid *Housewife* receive a definite salary), may be entered *Housework*, or *At home*, and children, employed, as *At school* or *At home*.

c. Be taken to report specifically the occupations engaged in domestic service for *Ward*, *Cook*, *Housemaid*, etc. If the person has been changed or given up on account of CAUSING DEATH, state occupation at time of illness. If retired from business, that should be indicated thus: *Farmer (retired, 6 yrs.)* who have no occupation whatever,

Statement of cause of death.—Name, first, and last, of CAUSING DEATH (the primary affection and time and causation), using always the same term for the same disease. Examples: *Scarlet 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 *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.)