

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

1 PLACE OF DEATH

County **Jackson**

399

Township **Kaw**

Registration District No. **1002**

File No. **34517**
5571

Village **Kansas City**

Primary Registration District No. **130 South Cypress**

Registered No.

City **Kansas City**

(NO. **130 South Cypress** St. Ward)

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

2 FULL NAME **James Proctor Nesbit**

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE MARRIED WIDOWED OR DIVORCED **Married**
(Write the word)

16 DATE OF DEATH **October 25th 1916**
(Month) (Day) (Year)

6 DATE OF BIRTH **September 18th 1860**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from **June 1, 1916** to **Oct 25, 1916**, that I last saw him alive on **Oct 24, 1916**, and that death occurred, on the date stated above, at **3:30** a.m.

7 AGE **56** yrs. **1** mos. **7** ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

8 OCCUPATION (a) Trade, profession, or particular kind of work **Lawyer**
(b) General nature of industry business or establishment in which employed (or employer) **Abstract's & Titles**

(Duration) **97** yrs. mos. ds.

9 BIRTHPLACE (City or town, State or foreign country) **Kansas**

CONTRIBUTORY (Secondary)

PARENTS 10 NAME OF FATHER **Robert T. Nesbit**
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) **Kentucky**
12 MAIDEN NAME OF MOTHER **Wm Knott**
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) **Kentucky**

(Signed) **A. W. Thompson M.D.**
Oct 25, 1916 (Address) **117 1/2 Kingston**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) **Mrs. Annie M. Nesbit**
(Address) **130 South Cypress**

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

15 **OCT 26 1916** Filed **1916** Registrar **Geo. F. Miller**

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place **1** yrs. mos. ds. In the **1** State yrs. mos. ds.

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

19 PLACE OF BURIAL OR REMOVAL **Forest Hill** DATE OF BURIAL **Oct 25, 1916**

20 UNDERTAKER **Shire & McCallister and Co** ADDRESS

924 - 6 Oak St Kansas City Mo.

PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. It may be properly classified.

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.)

WRITE PLAINLY, WITH INK. THIS IS A PERMANENT RECORD.

Every item of information should be stated EXACTLY. PHYSICIANS of state should state date of death in plain form, so that it may be properly classified. Exact statement of OCCUPATION is very important.

84133
1 PLACE OF DEATH

2430

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

County
Township Registration District No. 399 File No.
or
Village Primary Registration District No. 1002 Registered No. 3571
or
City Kansas City (NO. 130 South Cypress St.) Ward
If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Brewster Nesbit

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F
4 COLOR OR RACE W
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M
6 DATE OF BIRTH
7 AGE If LESS than 1 day hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country)
PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
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) (Address)

15 Filed Oct 26 1916 Thos. F. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 25 1916
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191..... that I last saw him alive on 191..... and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

CONTRIBUTORY (Secondary) Astero Sclerosis
(Duration) yrs. mos. ds.
W. G. Thompson M. D.
Oct 25 1916 (Address) 1111 7th

*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 DATE OF BURIAL 191.....
20 UNDERTAKER ADDRESS

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