

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 **41020**

1 PLACE OF DEATH

County Jackson
Township Kaw
or
Village
or
City Kas. City

Registration District No. 5
Primary Registration District No.
(No. N. E. Cor. 5th & Highland)

File No.
Registered No. 1026
Ward

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

2 FULL NAME Edmund Davison McElroy

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH July 20, 1872
(Month) (Day) (Year)

7 AGE 44 yrs. 4 mos. 19 ds.
If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Deputy clerk County Collectors Office
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Ky.

PARENTS
10 NAME OF FATHER Antony McElroy
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky.
12 MAIDEN NAME OF MOTHER Elizabeth Irvin
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edmund D. McElroy
(Address) 809 Victor Bldg.

DEC 10 1916
Filed..... 1916 Jos. F. Miller
Registrar

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from Dec 10th 1916 to Dec 10th 1916, that I last saw him alive on Dec 10th 1916, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Uraemia
132 1/2 / 50

(Chr) (Duration) 10 hours
CONTRIBUTORY Interstitial Nephritis
(Secondary) (Duration) about 1 yr mos. ds.

(Signed) E. R. Barry M. D.
Dec 10th 1916 (Address) 702 Bryant Bldg.

*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 20 State.....yrs.....mos.....ds.
Where was disease contracted if not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Springfield Ky. DATE OF BURIAL 10/13 1916

20 URBERTAKER Miss McElroy ADDRESS 924 Oak

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, peritonacum*, 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.)

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 41020
 Township Jackson Primary Registration District No. 1003 Registered No. 4026
 City Jac City (No. N.E. Cor. 5th & Highland St. _____ Ward)

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Mo. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20, 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
44 4 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Deputy clerk (duration) _____ yrs. _____ mos. _____ da.

(b) General nature of industry, business, or establishment in which employed (or employer) County Collector

(c) Name of employer J. Q. Watkins, County Collector

9. BIRTHPLACE (CITY OR TOWN) Springfield
 (STATE OR COUNTRY) Washington Co.,

10. NAME OF FATHER Anthony C. McElroy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Springfield,
 (STATE OR COUNTRY) Washington Co. Ky.

12. MAIDEN NAME OF MOTHER Janet C. Irvine
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) near Danville
 (STATE OR COUNTRY) Boyle Co. Ky.

14. INFORMANT Emmet F. McElroy,
 (Address) 809 Victor Bldg., Kansas City

15. FILED 12-16-16 M M Crowe
Dist. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 10 1916

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY _____
 SECONDARY _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield, Kentucky DATE OF BURIAL Dec. 13 1916

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. N. B.—Every item of information should be carefully checked and properly classified. Exact cause of death in plain terms, so that it may be properly classified. Exact cause of death in plain terms, so that it may be properly classified. Exact cause of death in plain terms, so that it may be properly classified.

SUPPLEMENTARY

