

## 1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty JacksonTownship Kaw.Village Kansas CityCity Kansas CityRegistration District No.         Primary Registration District No.         (No. Parkdale Hotel St.          Ward         )File No. 1459Registered No.         

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

2 FULL NAME John Herbert Van Closter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED, WIDOWED OR DIVORCED (Write the word) Married6 DATE OF BIRTH UNKNOWN  
(Month) (Day) (Year)7 AGE About 60 yrs. mos. ds. If LESS than 1 day hrs. or min.?8 OCCUPATION  
(a) Trade, profession, or particular kind of work Hotel Proprietor  
(b) General nature of industry, business, or establishment in which employed (or employer) Denver, Colo.9 BIRTHPLACE  
(City or town, State or foreign country) Belgium10 NAME OF FATHER John Van Closter11 BIRTHPLACE OF FATHER  
(City or town, State or foreign country) Belgium12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER  
(City or town, State or foreign country) Holland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Helen Van Closter(Address) Parkdale Hotel

15

Filed JAN 17 1917Registrar Thos. F. Miller

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 16 1917  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from July 8, 1917, to Jan. 7, 1917, that I last saw him alive on Jan. 7, 1917, and that death occurred, on the date stated above, at 1p m.

The CAUSE OF DEATH\* was as follows:

Progressive Pernicious Anemia.811 177  
(Duration) 1 yrs. mos. ds.CONTRIBUTORY Accidental Traumatism of chest about a year ago  
(Secondary) (Duration) yrs. mos. ds.(Signed) Maclay Lyon, M. D.Jan. 17, 1917 (Address) 501 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. 3 mos. ds. In the 16 yrs. mos. ds. StateWhere was disease contracted Place of death  
if not at place of death?Former or usual residence Metropole Hotel

19 PLACE OF BURIAL OR REMOVAL

Cremation

DATE OF BURIAL

Jan. 18, 1917

20 UNDERTAKER

ADDRESS

W. W. Newcomer, 2111 E. 9th

# 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Jackson REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

Township ..... Registration District No. 399 File No. ....

Village ..... Primary Registration District No. 1002 Registered No. 285

City Kansas City St. \_\_\_\_\_ W. (Pa) \_\_\_\_\_

2 FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year) .....

7 AGE ..... yrs. .... mos. .... ds. 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) .....

16 DATE OF DEATH ..... (Month) ..... (Day) ..... 191..... (Year)

17 I 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 ..... m. The CAUSE OF DEATH\* was as follows:

Progressive Pernicious Anemia

(Duration) 1 yrs. .... mos. .... ds.

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) .....

CONTRIBUTORY Traumatism of chest abt accidental fall from hay loft (Duration) 1 yrs. .... mos. .... ds.?

(Signed) Maclay G. G. D. 1-17, 191..... (Address) 501 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.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) ..... (Address) .....

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 .....

15 Filed 1-17, 191..... 7 Thos. F. Miller Registrar

19 PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL ..... 191..... ADDRESS ..... 20 UNDERTAKER .....

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*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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *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.)

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