

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

1 PLACE OF DEATH

County Jackson  
Township Ruw  
or  
Village  
or  
City Kansas City (NO. 308 Cherry St., Ward)

Registration District No. File No. 13261  
Primary Registration District No. Registered No.

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

2 FULL NAME Angela Carrera

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH aug 15 (Month) (Day) (Year)

7 AGE 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work House wife (b) General nature of industry business or establishment in which employed (or employer) none

9 BIRTHPLACE (City or town, State or foreign country) Italy *eastern section*

PARENTS  
10 NAME OF FATHER Vittorio Oddo  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Italy  
12 MAIDEN NAME OF MOTHER Giuseppina Galazotto  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Vito Carrera (Address) 308 Cherry

15 Filed APR 28 1918 Ada Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 13 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from apr 3 1918 to apr 13 1918 that I last saw her alive on apr 13 1918 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH\* was as follows:  
Streptococci pyaemia  
36  
150 B. g. D  
88 (Duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.  
(Signed) Joseph W. Howard M. D. Apr 15 1918 (Address) 910 Realto Bet

\*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 with St. Michael's DATE OF BURIAL April 15, 1918

20 UNDERTAKER A. Beckett ADDRESS 538 Commercial

# 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, Låborer—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; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum*, 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 child-birth or miscarriage, as "*PUERPERAL septichaemia*," "*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.)

DR. JOSEPH W. HOWARD  
SUITE 910 RIALTO BUILDING  
KANSAS CITY, MO.

August 13, 1919.

te Board of Health,

Jefferson City, Mo.

tlemen:-

Replying to your inquiry relative to Angelo Caruso  
ld say that this was not a puerperal case. The  
ection for which I was called was in the eye balls  
she had abscesses in the body. ✓

Trusting this information is what you desire, I am

Yours very truly,



-R?

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

**1. PLACE OF DEATH**

County Missouri Registration District No.                      File No. 13261  
 Township                      Primary Registration District No.                      Registered No.                       
 City                      (No.                     ) 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,                      hr.                      min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work                      (duration) yrs. mos. ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer)                       
 (c) Name of employer                     

9. BIRTHPLACE (CITY OR TOWN)                       
 (STATE OR COUNTRY)                     

10. NAME OF FATHER                     

11. BIRTHPLACE OF FATHER (CITY OR TOWN)                       
 (STATE OR COUNTRY)                     

12. MAIDEN NAME OF MOTHER                     

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)                       
 (STATE OR COUNTRY)                     

14. INFORMANT                       
 (Address)                     

15. FILED                      19                     

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 13 19 18  
 17. I HEREBY CERTIFY, That I attended deceased from                      19                     , to                      19                     , and that I last saw                      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. ds.

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)                      L. 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL                      DATE OF BURIAL                     

19

20. UNDERTAKER                      ADDRESS                     

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

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"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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which gives any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.