

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 Kaw
Village
or
City Kansas City, Mo.

309
Registration District No. 1000 File No. 26638
Primary Registration District No. 3590 Registered No. 3590
(No. General Hospital St. Ward)

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

2 FULL NAME Mrs. Leonard O. Moore
(Reland)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
6 DATE OF BIRTH <u>June 15</u> 18 <u>85</u> (Month) (Day) (Year)		
7 AGE <u>33</u> yrs. <u>2</u> mos. <u>11</u> ds.		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Nurse</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>1338</u>		
9 BIRTHPLACE (City or town, State or foreign country) <u>Colorado</u> <u>12</u>		
PARENTS	10 NAME OF FATHER <u>E. C. Hoskinson</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u>	
	12 MAIDEN NAME OF MOTHER <u>M. E. Hyde</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Barren County Mo</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. R. A. Young
(Address) Mayville Mo

15 Filed AUG 30 '18 1918
Edw. E. Emswiler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 26 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Deputy Coroner 1918
that I last saw h. alive on 1918
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Pneumonia
1338
12

CONTRIBUTORY (Secondary) Illis Salitis
(Duration) yrs. mos. ds.
(Signed) J. D. Dunder M. D.
5 29, 1918 (Address) 1215 - 1/2

*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 Mayville Mo DATE OF BURIAL 8/30 1918

20 UNDERTAKER Curry & Tobin Co ADDRESS 20 Hunter Ave

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, 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 child-birth 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.)

Duplicate

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

Do not use this space.

26638

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
Township East Primary Registration District No. 1802 Registered No. 3590
City Kansas City (No. General Hospital St. _____ Ward)

2. FULL NAME L. Catherine Schly

(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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15 - 1885

7. AGE YEARS 33 MONTHS 2 DAYS 11 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nurse
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Colorado

FATHER 13. NAME S. C. Hoskinson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

MOTHER 15. MAIDEN NAME M. E. Hyde

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va. Co.

17. INFORMANT Mrs. B. A. Young (ADDRESS) Mayville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mayville Mo DATE 8-30-18

19. UNDERTAKER Quirk & Sobin (ADDRESS) _____

20. FILED Aug 30, 18 Ada Thomas Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 26, 1918

22. I HEREBY CERTIFY that I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pyo nephrosis Date of onset _____
1338
1203
Other contributory causes of importance: Colitis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so specify _____ (Signed) J. S. Snider, M. D.
8/29 (Address) 10 - 15 Reuter