

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

PLACE OF DEATH  
County Newton  
Township Berwick  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 612 File No. 47717  
Primary Registration District No. 6257 Registered No. 26

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

FULL NAME Charles William Kissel

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE wh SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Sept 24, 1891  
(Month) (Day) (Year)

AGE 27 yrs. 3 mos. 7 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION : (a) Trade, profession, or particular kind of work : mining Machine man.  
(b) General nature of industry, business, or establishment in which employed (or employer) Line mining

BIRTHPLACE (City or town, State or foreign country) Lee Summit, Mo.

PARENTS  
NAME OF FATHER Wm Kissel  
BIRTHPLACE OF FATHER Williamport, Penn.  
(City or town, State or foreign country)  
MAIDEN NAME OF MOTHER Anne Mary Hoffman  
BIRTHPLACE OF MOTHER Lawrence Co., Mo.  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs A.M. Kissel  
(ADDRESS) Wintworth, Mo #2

Filed Jan 11, 1919 Geo Saunders.  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 31st, 1918  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 27, 1918, to Dec 31, 1918, that I last saw him alive on Dec 30, 1918, and that death occurred, on the date stated above, at 11 A.M.  
The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Phthisis  
2311  
(Duration) 1 yrs. 11 mos. 11 ds.

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) F. H. Clark M. D.  
Dec 31, 1918 (Address) Fair City, Mo.

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

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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_  
UNDERTAKER ✓ ADDRESS \_\_\_\_\_

**PLACE OF DEATH**

County.....

Township \_\_\_\_\_  
or \_\_\_\_\_

Village \_\_\_\_\_  
or \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_

Ward \_\_\_\_\_

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_  
SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_  
WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_  
(Write the word)

DATE OF BIRTH \_\_\_\_\_ (Day) \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) \_\_\_\_\_

AGE \_\_\_\_\_ (Year) \_\_\_\_\_

IF LESS than \_\_\_\_\_  
1 day \_\_\_\_\_ hrs \_\_\_\_\_  
or \_\_\_\_\_  
\_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds \_\_\_\_\_ or min.?

OCCUPATION \_\_\_\_\_  
(a) Trade, profession, or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE \_\_\_\_\_  
(City or town, State or foreign country)

NAME OF FATHER \_\_\_\_\_

BIRTHPLACE OF FATHER \_\_\_\_\_  
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER \_\_\_\_\_  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_

REGISTRAR \_\_\_\_\_

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

Revised Uniform Standard

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Day) \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased free \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ an \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

191\_\_\_\_ (Address) \_\_\_\_\_ M. D. \_\_\_\_\_

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSPORTS, RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL OR REMOVAL \_\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

PLACE OF DEATH

County

Township

City

*Newtown  
Beverick*

Registration District No.

Primary Registration District No.

*612*

*6257*

File No.

Registered No.

*26*

(No.)

St.

Ward

FULL NAME

*Charles William Kiesel*

(a) Residence No.

(Usual place of abode)

St.

Ward

(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**

SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*M*

*W*

*M*

MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR)

AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

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

(c) Name of employer

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)

INFORMANT

(Address)

FILED *Feb 13* 19 *19* *George Saunders*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

*Dec 31 1918*

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to ..... 19.....

that I last saw him alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*Beverick C.P. Cemetery*

*Jan 1 1919*

20. UNDERTAKER

ADDRESS

*Tom Hessel*

*Prine City Mo.*

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

# 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

*pneumonia* ("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 give 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.