

30 ml

D. Smith

STATE OF ~~KANSAS~~ *Missouri* STANDARD
State Board of Health—Division of Vital Statistics CERTIFICATE OF DEATH

Do not write
19835
in this space.

1 PLACE OF DEATH: County Bates 48
Township Homer Registered No. 5072
or City _____ No. 5072 St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME William Dorney
(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 Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married
5a If married, widowed, or divorced HUSBAND or (or) WIFE of Sabel Dorney
6 DATE OF BIRTH (month, day, and year) Feb 2 - 1848
7 AGE Years 73 Months 6 Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED Farmer
(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

9 BIRTHPLACE (city or town) James
(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 Ben Dorney
(Address) Rt 2 - _____

15 Filed Sept 8, 1921 Arnot
Elsie Williams Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1921
17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921, to Aug 30, 1921, that I first saw h.s. alive on Aug 20, 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH * was as follows:
Endocarditis
Denti
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____
(Signed) J. M. Smith, M. D.
. 19 (Address) Arnot

* 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 Berlin Cemetery DATE OF BURIAL Sept 1 - 1921

20 UNDERTAKER R. W. Lee ADDRESS Arnot

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

of Death.

proved by U. S. Census and American Public Health Association.]

Contributory.

ent 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 specifications, 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*, *At home*, and children, not gainfully employed, *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Maids*, *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 stated 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 accepted term for the same disease. Examples: *Spinal meningitis* (the only definite synonym is *Spinal meningitis*); *Diphtheria* (the only definite use of "Croup"); *Typhoid fever* (never return "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is incorrect); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

(secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (the disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia," "Coma," "Convulsions," "Debility" ("Congenital debility," "Senile," etc.), "Dropsy," "Exhaustion," "Hemiplegia," "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 disease," "Puerperal peritonitis," etc. State quality all for which surgical operation was undertaken. VIOLENT DEATHS state MEANS OF INJURY and as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or surgically such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by train—accident*; *Revolver wound of head—suicide*; *Poisoned by carbolic acid—probably accidental*. The nature of the injury, as fracture of skull, etc., and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory." (Recommendation of the Committee on Nomenclature of the American Medical Association.)

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

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.