

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

1073

1. PLACE OF DEATH

County Jackson
Township St. Lawrence
City St. Mary, Mo. (No. St. Mary Hosp)

Registration District No. 388
Primary Registration District No. 1009

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Louis Blutoy Stone
(a) Residence No. 1415 Linwood St. _____ Ward _____
(Usual place of abode)
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.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|-------------------------------|---|
| 3. SEX <u>m</u> | 4. COLOR OR RACE <u>wh</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>single</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct 14, 1921</u> | | |
| 7. AGE | YEARS | MONTHS |
| | <u>1</u> | <u>2</u> |
| | | DAYS |
| | | <u>22</u> |
| 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u> (c) Name of employer | | |

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

| | |
|---------|--|
| PARENTS | 10. NAME OF FATHER <u>P. C. Stone</u> |
| | 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____ |
| | 12. MAIDEN NAME OF MOTHER <u>Rosa M. Oden</u> |
| | 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____ |

14. INFORMANT P. C. Stone
(Address) 1415 Linwood

15. FILED 1/7, 1923 M. M. Crowe

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6, 1922

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1922 to Jan 6, 1922 that I last saw him alive on Jan 6, 1922, and that death occurred, on the date stated above, at 10:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Intestinal obstruction
2 1/2 (duration) yrs. mos. 2 ds.
CONTRIBUTORY toxaemia of obstruction
(SECONDARY) (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATIVE PRECEDE DEATH? no DATE OF Jan 6-23

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? laparotomy
(Signed) Dred G. Hatch, M. D.
16 (Address) 307 Bonfils Bldg

*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 Clinton mo DATE OF BURIAL Jan-8, 1922

20. UNDERTAKER Ross & Co ADDRESS 157 Jackson

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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 neoplasma); *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.

STANDARD CERTIFICATE OF DEATH

Jan 19 23
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Jackson State MISSOURI Registered No. 1073
 Township _____ or Village 1002 _____ or
 City Kansas City No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Louis Clinton Stone
 (a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
 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.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX m **4 COLOR OR RACE** w **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** s
(write the word)

16 DATE OF DEATH (month, day, and year) Jan 6 19 23

5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
 that I last saw h_____ alive on _____, 19____,
 and that death occurred, on the date stated above, at _____m.
 The CAUSE OF DEATH* was as follows:

6 DATE OF BIRTH (month, day, and year) _____

7 AGE Years _____ Months _____ Days _____
IF LESS than 1 day, hrs. or min.

8 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 _____

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

9 BIRTHPLACE (city or town) _____
 (State or country) _____

18 Where was disease contracted
 If not at place of death? _____

10 NAME OF FATHER _____

Did an operation precede death? _____ Date of _____

11 BIRTHPLACE OF FATHER (city or town) _____
 (State or country) _____

Was there an autopsy? _____

12 MAIDEN NAME OF MOTHER _____

What test confirmed diagnosis? _____

13 BIRTHPLACE OF MOTHER (city or town) _____
 (State or country) _____

(Signed) _____, M. D.
 _____, 19 (Address)

14 Informant _____
 (Address) _____

19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ **DATE OF BURIAL** _____

15 Filed 1/7, 1923 M. M. Crowe
 REGISTRAR

20 UNDERTAKER _____ **ADDRESS** _____

SUPPLEMENT

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