

Exact statement of OCCURRENCE of disease in plain terms, so that it may be properly classified. See instructions on back of certificate.

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

Do not write
1525
in this space

1 PLACE OF DEATH: County Joplin ✓
Township Walton Registered No. ## 411
or City Joplin No. 2002 St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME May Jane Kembrough (1)
(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 Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) widow
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) ✓
7 AGE Years 64 Months NY Days 15 If LESS than 1 day _____ hrs. or _____ min.
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Handkercher
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

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

10 NAME OF FATHER Milton Walker

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

12 MAIDEN NAME OF MOTHER Louisa Ross

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

14 Informant J. M. Butler
(Address) Joplin M. R. B.

15 Filed 2 12 1925 W. J. S. [Signature] Registrar

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) Jan 7 1923
17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1922, to Jan 2 1923, that I last saw her alive on Jan 2 1923, and that death occurred, on the date stated above, at 10:30 am.

The CAUSE OF DEATH * was as follows:
Chronic interlobular nephritis
131

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

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

Did an operation precede death? no Date of _____
Was there an autopsy? no

What test confirmed diagnosis? _____
(Signed) J. M. Butler M. D.
_____ 702 (Address) Chilwood mo

* 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 Oak Hill DATE OF BURIAL Jan 7 1923

20 UNDERTAKER W. J. S. [Signature] ADDRESS Galena

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 neoplasms); *Measles*;

ate
 Example: ease 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.

1 PLACE OF DEATH

County Jasper

Township _____

Village _____

City Joplin (No. _____ St.; _____ Ward)DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of _____

Registered No. _____

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

2 FULL NAME May Jane Kimbrough

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED W
(Write the word)6 DATE OF BIRTH July 29, 1858
(Month) (Day) (Year)

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

8 OCCUPATION

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4, 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, 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.

(Signed) _____, M. D.

_____, 191____ (Address) _____

* 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 _____

DATE OF BURIAL _____, 191____

20 UNDERTAKER _____

ADDRESS _____

REGISTRAR

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atic), *Impotency*, *Senility*, *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.)

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