

MARGIN RESERVED FOR BINDING

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.

Missouri
STATE OF KANSAS

STANDARD
CERTIFICATE OF DEATH

Do not write
8808
in this space

State Board of Health—Division of Vital Statistics

1 PLACE OF DEATH: County Jackson ³⁹⁵
Township One-Bur Registered No. 4232
City Blue Springs No. 12 St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME Mary Ann Hopkins
(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.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Hopkins
6 DATE OF BIRTH (month, day, and year)
7 AGE Years 79 Months 8 Days 29 If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10 NAME OF FATHER Robt Tucker

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

12 MAIDEN NAME OF MOTHER Flachie Bell

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

14 Informant Georgia Cady
(Address) 1012 E 15th St. Blue Springs Mo

15 Filled Mar 3, 1923
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to Mar 3, 1923.
that I last saw her alive on Mar 1, 1923.
and that death occurred, on the date stated above, at 7:26 a.m.

The CAUSE OF DEATH * was as follows: Bronchitis
Pneumonia catarrhal
107A
HIE
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hyphastatic cough
(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) Joseph S. St. John, M. D.
, 10 Blue Springs Mo (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, CREATION, OR REMOVAL Blue Springs Mo DATE OF BURIAL Mar 4 1923

20 UNDERTAKER J W Stanley ADDRESS Gardner Kan

V. S. No. 98

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*, *Compositor*, *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*;

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.

1 PLACE OF DEATH

County Jackson
 Township _____
 or Blue Springs
 Village _____
 or _____
 City _____ (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 Mary Ann Hopkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX W 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M

6 DATE OF BIRTH X June 3, 1943
 (Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ mln. ?

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) _____

PARENTS
 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) _____

15 Filed June 24, 1943 J. W. Little, M.D.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 2 - 1943
 (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

20 UNDERTAKER

ADDRESS

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