

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

*How 9989  
3239*

**399**

**1. PLACE OF DEATH**

County Jackson  
Township New  
City Kansas City (No. 412 E. 17<sup>th</sup>)

Registration District No. 2003  
Primary Registration District No. 2003

File No. \_\_\_\_\_  
Registered No. 1451  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Amanda Webster Lewis

(a) Residence No. 412 E. 17<sup>th</sup> 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fe 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>62</u>	<u>62</u>	<u>11</u>	<u>3</u>	

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) unknown

14. INFORMANT Mrs. Mary Martin  
(Address) 11611 Oak St.

15. FILED 3/28 1923 J.A.M. Crowe  
REGISTRAR Dep

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/27 19 23

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1922 1922 to Nov 14 1922 1922  
that I last saw h. alive on Nov 14 1922 1922 and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

148  
46  
Carcinoma of uterus  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY (SECONDARY) 46  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH: Home

1 DID AN OPERATION PRECEDE DEATH: yes DATE OF 11/10/22

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS: Autopsy  
(Signed) Wm. Jackson Spicer M.D.  
3/27 1923 (Address) Ball Hospital

\*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 Topoka Kansas DATE OF BURIAL Mar 27 1923

20. UNDERTAKER Watkins Bros. ADDRESS 1729 Lydia

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.

RECORD

# 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 child-birth 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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

## STANDARD CERTIFICATE OF DEATH

County .....

Township .....

or

Village .....

or

City .....

(No. ....)

St.; ..... Ward)

State of .....

Registered No. ....

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

## 2 FULL NAME

Amanda Webster Lewis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED M  
(Write the word)6 DATE OF BIRTH ..... 1 (Year)  
(Month) (Day)7 AGE ..... yrs. .... mos. .... ds. or ..... min. ?  
If LESS than 1 day, .... hrs.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) Unknown

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 5-17 1917 M M Crow  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 27 1917  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...  
that I last saw him alive on ..... 191...  
and that death occurred, on the date stated above, at ..... m.  
The CAUSE OF DEATH\* was as follows:Contributory (SECONDARY) .....  
(Duration) ..... yrs. .... mos. .... ds.Signed ..... M. D.  
, 191... (Address) .....

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) DISEASE or 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 .....

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

B. 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. See instructions on back of certificate.

U.S. GO. 28

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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RECEIVED  
FEBRUARY 19 1914