

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

8316

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. 1490
 Township Kaw Primary Registration District No. _____ Registered No. 1490
 City Kansas City (No. 2604 Edgewood) St. _____ Ward _____

2. FULL NAME

Marcus Payne Biggers
 (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

1. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Margaret Biggers</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec. 10, 1869</u>		
7. AGE	YEARS	MONTHS
<u>53</u>	<u>0</u>	<u>16</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>conductor</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>M & R Ry 97</u> (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
PARENTS	10. NAME OF FATHER <u>Sam Biggers</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>	
	12. MAIDEN NAME OF MOTHER <u>No Record</u>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>		
14. INFORMANT <u>Margaret Biggers</u> (Address) <u>2604 Edgewood</u>		
15. FILED <u>3/31/23</u> <u>M. M. Cravo</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 29, 1923

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1922, to March 29, 1923, and that I last saw him alive on March 28, 1923, and that death occurred, on the date stated above, at 7:10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage - paralytic stroke
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Arterio sclerosis
 (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? Clinical
 (Signed) W. A. Sherman M. D.
3/29/23 (Address) 2201 E 18th St KCMO

*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
Forest Hill DATE OF BURIAL 4-2-1923

20. UNDERTAKER
Mrs. L. L. Lanster ADDRESS K. C. Mo.

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: "Certificate 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

*Dr. Enloe -
This patient (Mr. Biggs) had a
high blood pressure with arterio sclerosis (498) ^{living about}
to his illness - but ^{he} ^{is} ^{probably} ^{exhausted} ^{and} ^{has} ^{recently} ^{been} ^{convinced}
evidence of ^{stroke} ^{completely} ^{exhausted} ^{and} ^{has} ^{recently} ^{been} ^{convinced}
10 months ^{ago} ^{and} ^{is} ^{now} ⁱⁿ ^{the} ^{same} ^{condition}
irreversible ^{and} ^{is} ^{now} ⁱⁿ ^{the} ^{same} ^{condition}
than ^{before} ^{and} ^{is} ^{now} ⁱⁿ ^{the} ^{same} ^{condition}
date*

The enclosed certificate is defective for the reason, that the precise form of Paralysis should be stated, as, Acute Ascending Paralysis, Paralysis Agilis, Bulbar Paralysis, etc. Write General Paralysis of the Insane in full. Distinguish Paraplegia and Hemiplegia, and in the latter, when sequel of Apoplexy of Cerebral Haemorrhage, report the primary cause.

Please correct, sign and return together with this card.

DR. CORTEZ F. ENLOE,
State Registrar.

Q316 1923

RECEIVED
FEB 10 1923
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

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

H. 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.

1 PLACE OF DEATH

County _____

Township _____

Village _____

City Kansas City (No. 1002)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of _____

Registered No. 1498

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

2 FULL NAME Marcus Payne Biggers

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____, 19____, _____
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds.
If LESS than 1 day, _____ hrs. _____ 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) _____

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 Filled 3/31, 1923 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 29, 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Paralytic Stroke
Cerebral Hemorrhage followed by
hemiplegia (Complete) (Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) [Signature]
_____, 19____ (Address) _____

* State the DISEASE CAUSING DEATH, or, in death 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 _____, 19____

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTAL

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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