

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

12592

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. \_\_\_\_\_  
Township Law Primary Registration District No. 1002 Registered No. 1510  
City K.C. Mo. (No. 204-E-43rd St) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Emma Maria Eulank  
(n) Residence. No. 204-E-43rd 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 Wh 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) Apr - 2 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
63 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None  
(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) Virginia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) not know

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14. INFORMANT Mrs. C. W. Edgerds  
(Address) 204 E-43rd St

15. FILED 4/2/23 M.M. Brown  
RECORDS

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr - 2 - 1923

17. I HEREBY CERTIFY, That I attended deceased from 1-1-23, 19\_\_\_\_, to 4-1-23, 19\_\_\_\_, that I last saw her alive on 4-1-23, 19\_\_\_\_, and that death occurred, on the date stated above, at 9:30 AM m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Myocarditis  
IXIA

CONTRIBUTORY Apoplexy 5 yrs ago  
(SECONDARY) Broken left hip 6 months ago

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) Geo F Penstemon M. D.  
1923 (Address) 605 Bryant 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 DATE OF BURIAL

Fountain, Colo. 4-4 1923

20. UNDERTAKER ADDRESS

Mrs. C. L. Forster K.C. Mo.

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.

600  
1-4-1918

# 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: "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.

## 1 PLACE OF DEATH

County Jackson  
 Township Kaw  
 or  
 Village Kansas City  
 or  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

## 399 STANDARD CERTIFICATE OF DEATH

1519

Registered No. \_\_\_\_\_

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

## 2 FULL NAME

Emma Marie Embank

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH April 2, 1860  
(Month) (Day) (Year)

7 AGE 63 yrs. 0 mos. 0 ds. If LESS than 1 day, --- hrs. or --- min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. None  
 (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) \_\_\_\_\_

15 Filed 4/2 1923 M. M. Crowe REGISTRAR

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1923 to \_\_\_\_\_, 1923, and that death occurred on the \_\_\_\_\_ date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH was as follows:

185  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory Broken Left Hip  
 (Secondary) Typhoid - Accidental loss of teeth  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Geo A. Vanstetter, M. D.

\* 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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