

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

12621

1. PLACE OF DEATH  
 County Jackson Registration District No. 399 File No. \_\_\_\_\_  
 Township Race Primary Registration District No. 1002 Registered No. \_\_\_\_\_  
 City Kansas City (No. 3015 Waldron) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Frances Gleason Hughes  
 (a) Residence No. 3015 Waldron St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3 MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 3 1923

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

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1922 to April 3 1923 that I last saw her alive on April 3 1923, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 19 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
74 6 14

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

cardio-renal-vascular  
131

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

92  
97 (duration) \_\_\_\_\_ yrs. 6 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) Maryville  
 (STATE OR COUNTRY) New York

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

10. NAME OF FATHER W M Gleason

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS:

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

(Signed) H. A. Brynjole M. D.

12. MAIDEN NAME OF MOTHER Malinda Sherman

(4-7-1923) (Address) 1222 Platte Bldg

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

\*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.)

14. INFORMANT Mrs. W. K. Hughes  
 (Address) 3015 Waldron

19. PLACE OF BURIAL CREMATION, OR REMOVAL St Scott. Co DATE OF BURIAL Apr 4 1923

15. FILED 4/4 23 M. M. Ceraue  
 \_\_\_\_\_  
 \_\_\_\_\_

20. UNDERTAKER Gleason K Davidson ADDRESS 3028 Trout

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 original); "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: "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 Jackson399  
1002DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

1558

## STANDARD CERTIFICATE OF DEATH

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City Kansas City (No. \_\_\_\_\_, Ward \_\_\_\_\_)

State of \_\_\_\_\_

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

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

## 2 FULL NAME

Frances Gleason  
3015 Waldron

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widow

16 DATE OF DEATH

April 3, 1923  
(Month) (Day) (Year)

6 DATE OF BIRTH

Sept 19, 1848  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

7 AGE

74 yrs. 6 mos. 14 ds. If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min. ?

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (for employer)

The CAUSE OF DEATH\* was as follows:

Cardio-renal, vascular  
chronic nephritis  
arterio-sclerosis  
nitral resuscitation  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9 BIRTHPLACE (State or country)

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ ds. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) 129, 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

\_\_\_\_\_

M. D.—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.

15

Filed

4/4, 1923 M. M. Browne

REGISTRAR

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