

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

399

12949

1. PLACE OF DEATH

County Jackson Registration District No. 1002 File No. 1007
 Town Hamersville Primary Registration District No. 1002 Registered No. 1007
 City Hamersville No. Old City Hospital St. 1007 Ward

2. FULL NAME

(a) Residence No. 3111-6-16th St 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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) don't know 1896

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-----------|----------|----------|--|
| | <u>27</u> | <u>?</u> | <u>?</u> | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Checker
 (b) General nature of industry, business, or establishment in which employed (or employer) Stash Freight
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Carrollton
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Jno. White

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Belle White

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
 (STATE OR COUNTRY)

14. INFORMANT Pauline Childs
 (Address) 3012 E 17th

15. FILED 4/25 1923 M. M. Crowe
 RECDYR

3. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-23-1923

17. I HEREBY CERTIFY, That I attended deceased from 4-23 1923, to 4-23 1923 that I last saw him alive on the 4-23-23 1923, and that death occurred, on the date stated above, at 11:15 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
3/6 3/6 not known (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: I do not know

DID AN OPERATION PRECEDE DEATH? yes DATE OF 4-13-23

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
 (Signed) Dr. J. K. Shannon, M. D.
4/24 1923 (Address) K. C. Mc

*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 Carrollton Mo DATE OF BURIAL 4/26 1923

20. UNDERTAKER Hatkins Bros. ADDRESS 1729 Lydia

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.

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

M. 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 Jackson
Township _____
or
Village _____
City Kansas City (No. _____) St.; _____ Ward _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

399
1002

STANDARD CERTIFICATE OF DEATH

1897

Registered No. _____

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

2 FULL NAME John White

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE Wal 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED D
(Write the word)

16 DATE OF DEATH April 23, 1923
(Month) (Day) (Year)

6 DATE OF BIRTH Unknown, 1896
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from 4-13, 1923, to 4-23, 1923,

7 AGE 27 yrs. ? mos. ? ds. or ? min. If LESS than 1 day, --- hrs.

that I last saw him alive on 4-23, 1923

and that death occurred, on the date stated above, at 9 a. m.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Checker
(b) General nature of industry, business, or establishment in which employed (or employer) Wabash Freight

The CAUSE OF DEATH* was as follows:

Septicemia following
bilateral Perine and
gangrene of both feet
legs (Duration) yrs. mos. ds.

9 BIRTHPLACE (State or country) Unknown

Contributory (Duration) yrs. mos. ds.

PARENTS
10 NAME OF FATHER _____
11 BIRTHPLACE OF FATHER (State or country) _____
12 MAIDEN NAME OF MOTHER _____
13 BIRTHPLACE OF MOTHER (State or country) _____

(Signed) Dr. J. F. Shannon for Deacon M. D.
(Address) _____, 191

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(Address) _____

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 _____

15 Filed 4/25 1923 M. M. Crowe
REGISTRAR

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191

20 UNDERTAKER _____ ADDRESS _____

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