

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

Do not use this space.

11240

**1. PLACE OF DEATH**

County Jackson Registration District No. ....  
Township Kaw Primary Registration District No. ....  
City Kansas City (No. 3010 McGee Street St. .... Ward)

File No. ....  
Registered No. 1520 St. .... Ward)

**2. FULL NAME** Amanda Jackson Withers

(a) Residence No. 3010 McGee Street 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF John Peter Withers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 20, 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 7 20

**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 .....

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

**PARENTS**  
10. NAME OF FATHER .....  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) .....  
12. MAIDEN NAME OF MOTHER .....  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) .....

14. INFORMANT (Address) H. T. Demiss  
7636 Wabash Ave.

15. FILED 4/12 34 M. M. Cerove REGISTRAR  
By

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11, 1924

17. I HEREBY CERTIFY, That I attended deceased from Apr 10, 1924, to Apr 11, 1924, that I last saw h. or alive on Apr 10, 1924, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) .....

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 .....

(Signed) T. W. Gayle, M. D.  
4/12, 1924 (Address) 7636 Wabash

\*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 Wm Washington Cem DATE OF BURIAL 4-11-24

20. UNDERTAKER Stine & M. C. Church ADDRESS 924 Oak

# 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; Broncho-pneumonia* ("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

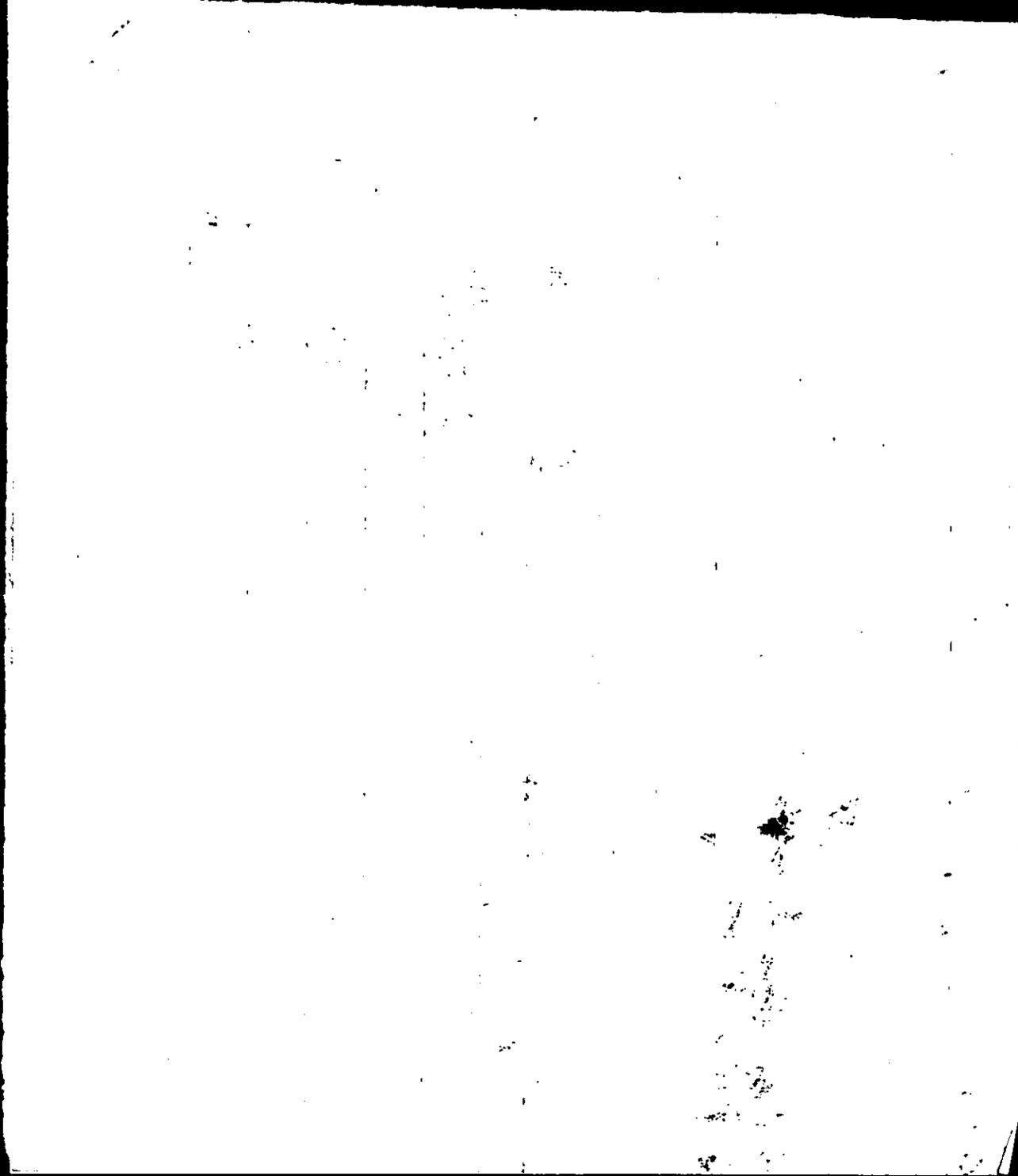
Keith & Perry D<sup>g</sup>  
N. C. Mo. May 7. 24

Dear Mr. Brown,

Ann of the opinion  
that if there were contributing  
causes in the case of Mrs. Amanda  
Jackson witness they were not appre-  
ciable. She fell in her yard, lost  
the use of one side lapsed into Coma  
& died in short time 12 to 15 hours.  
If I can do or say more that will  
be of service, I will be glad to do it.

Very truly yours,

J. W. Gayle, M. D.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Township Rau Primary Registration District No. \_\_\_\_\_ Registered No. 1520  
 City Keosauqua (No. 3010 Mc Bee St St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX \_\_\_\_\_ 4. COLOR OR RACE \_\_\_\_\_ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 11 1924

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

8. OCCUPATION OF DECEASED

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

Cerebral hemorrhage  
 (duration) yrs. mos. da. 14 d  
 CONTRIBUTORY kidney disease  
 (SECONDARY) (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

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) J. W. Gagle, M.D.

, 19\_\_\_\_ (Address) Keosauqua, Mo.

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12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

14. INFORMANT (Address) \_\_\_\_\_

15. FILED Apr 24 1924 M. M. Leroux REGISTRAR

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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