

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

Do not use this space.

11205

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Rox Primary Registration District No. _____
 City Kansas City (No. 3622 Forest Ave) St. _____ Ward _____
 File No. 1545
 Registered No. 1245

2. FULL NAME John S. Hollis

(a) Residence No. 3622 Forest St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 30 yrs. mo. _____ ds. _____
 How long in U.S., if of foreign birth? yrs. _____ mo. _____ ds. _____
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Annie L. Hollis
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 7th 1857
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 6 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Manager
 (b) General nature of industry, business, or establishment in which employed (or employer) White Sewing Machine
 (c) Name of employer Retired

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) West Virginia

10. NAME OF FATHER John Hollis
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Berkeley Co. (STATE OR COUNTRY) West Virginia
 12. MAIDEN NAME OF MOTHER Rebecca Chamberlayne
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) West Virginia

14. INFORMANT Annie L. Hollis (Address) 436 22 Forest Ave

15. FILED 4/14 1924 m. crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12th 1924
 17. I HEREBY CERTIFY, That I attended deceased from 1. P. 24 to 4. 12, 1924 that I last saw him alive on 4. 8, 1924, and that death occurred, on the date stated above, at about 8 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) Widow of long (duration) _____ yrs. _____ mo. _____ da.
3 yrs. _____ mo. _____ da.

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) Miss G. ... M. D.
4/13 1924 (Address) 25 Du. St. St. L.

*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 Memorial Park Cemetery DATE OF BURIAL 4-15 1924

20. UNDERTAKER John Fairweather ADDRESS 2424 Grant

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, Compositor, 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: "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.

Please name the disease
causing the dropsy of the
liver. A prompt reply will
be most appreciated.

yours truly,

M. M. Crow.

Obstruction of the Bile ducts as menad
could make out C.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County Jackson Registration District No. File No.
 Township Kaw Primary Registration District No. Registered No. 1543
 City St. Louis (No. St. Ward)

2. FULL NAME

John S. Hollis
 (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

MEDICAL CERTIFICATE OF DEATH

| | | |
|--|------------------|--|
| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) | | |
| 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 | | |
| 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) | | |
| 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) | | |

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 12 1924

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

THE CAUSE OF DEATH* WAS AS FOLLOWS
Cerebral Hemorrhage
Autopsy of liver

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?
 DID AN OPERATION PRECEDE DEATH? DATE
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS? (Signed) M. D. , 19..... (Address)

14. INFORMANT (Address)

15. FILED 4/14 24 M. M. Crowe REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 ADDRESS 19

20. UNDERTAKER ADDRESS

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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