

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

Do not use this space.

8119

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Registration District No. 1092
 City Kansas City (No. St. Joseph Hospital) St. _____ Ward _____

File No. _____
 Registered No. 1304

2. FULL NAME

Clara Matilda Davidson
 (a) Residence. No. Raytown mo. St. _____ Ward _____
 (Usual place of abode)
 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 Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-7-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 | 5 | 16

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER A. Bloom

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

12. MAIDEN NAME OF MOTHER Hannah Larson

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

14. INFORMANT John Davidson
 (Address) Raytown mo

15. FILED Feb 25 1925 M. M. Cereve
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar-23 1925

17. I HEREBY CERTIFY, That I attended deceased from March 12 1925 to Mar 23 1925 that I last saw her alive on Mar 23 1925 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Streptococci Septicemia
41 (duration) yrs. mos. 5 days
 CONTRIBUTORY Acute haemorrhagic nephritis
 (SECONDARY) (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED St. Joseph Hospital
 IF NOT AT PLACE OF DEATH? ja DATE OF Mar 12 1925
 DID AN OPERATION PRECEDE DEATH? No
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory culture
 (Signed) Oliver Hoffmann, M.D.
3/24 1925 (Address) 1235 Rialto 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 mt Wash - DATE OF BURIAL Mar 25 1925

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. mo.

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.

UNFADING INK—THIS IS A PERMANENT RECORD

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) *Colton 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 neoplasm); *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 ask the Physician
to state the cause for
the relief of which the
operation was performed.

1925
508119

(over)

Preceding the operation, which
was for retrimension of uterus, I dress-
ed a case which developed a frank
case of scarlatina the evening of the
day of operation and I believed that
the step to success was accidentally intro-
duced into the field of operation.

O. Hoffman M.D.

It is essential that death certificates be made complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: Clara Matilda Davidson

Who died at: St Joseph Hospital on Mar 23-1926

Residence: No. _____ St. Raytown Mo.
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Streptococcic Septicemia

Contributory: Acute Hemorrhagic Nephritis

Where was disease contracted? at hospital

Did operation precede death? yes Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? Blood culture

Name of physician: Orson Hofmann M.D.

Address of physician: 1235 Realts Bldg. R. E. Mo

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