

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

Do not use this space.

8288

1. PLACE OF DEATH

County Jackson Registration District No. 403 File No. _____
Township Brookings Primary Registration District No. 4238 Registered No. _____
City Independence (No. _____) St. _____ Ward _____

2. FULL NAME

Effie May Atkinson
(a) Residence. No. 50 Blue Ridge Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred 5 1/2 yrs. 7 mos. 16 ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29 - 1870
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 57 7 16
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) 2 mi. S.W. Raytown
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Geo. Davenport

11. BIRTHPLACE OF FATHER (CITY OR TOWN) 3 1/2 mi S.W
(STATE OR COUNTRY) Raytown, Mo

12. MAIDEN NAME OF MOTHER Sharon Frances West

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

14. INFORMANT E. S. Atkinson
(Address) Indep - Box R 5 Box 64

15. FILED _____ 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 13, 1926
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131
574
_____ (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____
_____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
_____ 19____ (Address)

*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 Brookings DATE OF BURIAL Dec 16 1926
ADDRESS _____

20. UNDERTAKER H. J. Ott & Co. ADDRESS Independence Mo.

PARENTS

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 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.

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

1. PLACE OF DEATH

County Jackson Registration District No. 403 File No. _____
 Township _____ Primary Registration District No. 4238 Registered No. 3
 City Independence St. _____ Word _____

2. FULL NAME

Essie May Atkinson

(a) Residence No. _____ 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX L 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 13 - 1925

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1925 to Mar 13 1925 that I last saw him on Mar 13 1925, and that death occurred, on the date stated above, at _____ 8 A. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29 - 1870

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 | 7 | 9 | 16

Cerebral Hemorrhage
 (duration) _____ yrs. _____ mos. 3 ds.
 CONTRIBUTORY (SECONDARY) Interstitial Nephritis
Chronic (duration) 10 yrs. _____ mos. _____ ds.

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 _____

18. WHERE WAS DISEASE CONTRAICTED? 1279

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

IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

10. NAME OF FATHER Geo DePort

WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs

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

(Signed) W. H. Galt, M. D.
 (Address) Raytown

12. MAIDEN NAME OF MOTHER Esther Francis

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brookings Cem DATE OF BURIAL Mar 15 1925

14. INFORMANT E. P. Atkinson
 (Address) Independence Mo

20. UNDERTAKER H. Galt ADDRESS Independence Mo

15. FILED Mar 15 1925 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.

CAUSE OF DEATH

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