

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

Do not use this space.

12027

1. PLACE OF DEATH

County Lackawn Registration District No. 404
Township Washington Primary Registration District No. 522.8
City Warsaw City (No. 1826) Maddi

File No. _____
Registered No. 15
St. _____ Ward _____

2. FULL NAME

Elizabeth Hill
(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

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 William D. Hill

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 | 3 | 25

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(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) Indiana

10. NAME OF FATHER Samuel Brazzil

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Waller

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

14. INFORMANT Mrs. J. W. Feeshure (Address) Greenwood Mo.

15. FILED 4-14-20 1925 A. Brannan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12 1925

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12 1925 to Apr. 12 1925, 1925 that I last saw h. s. a. l. alive on April 12 1925, and that death occurred, on the date stated above, at 5:30 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Violent Distention of Heart
70 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Bronchitis
(duration) yrs. mos. ds.

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. J. Jones, M. D.
4/12/25 19 (Address) 801 1/2 + Pass

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 Hutchison-Kansas DATE OF BURIAL 4-14 1925

20. UNDERTAKER Mrs. L. L. Foster ADDRESS K. O. Mo.

N. B.—Every item on this certificate should be so stated as to be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, as far as possible, should be stated.

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 septiemia," "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.

Elizabeth M. Leshure living at 412 So Oakley Avenue, in Kansas City, Missouri, of lawful age, first being duly sworn, on her oath says,

That to the best of her knowledge and belief the attached supplemental certificate is true and correct.

Further affiant saith not.

Elizabeth M Leshure

State of Missouri)

ss

County of Jackson)

Subscribed and sworn to before me, the undersigned, a Notary Public in and for said County and State, this 2nd., day of October, 1931

My Commission expires
January 2nd., 1935.

Paul Haltermire
Notary Public

RECEIVED

STATEMENT

1962-1963

12027

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 404
 Township Washington Primary Registration District No. 3338
 City Kansas City (No. 1826, Maddi) St. _____ Ward _____

File No. _____
 Registered No. 15

2. FULL NAME Elizabeth Gill

(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

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William A Gill
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 17 1894
 7. AGE YEARS 89 MONTHS 8 DAYS 25 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 13. NAME Joshua Russell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

15. MAIDEN NAME Nancy Guillen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Elizabeth A. Leskure
 (ADDRESS) 411 South Oakley St. C. 2nd

18. BURIAL, CREMATION, OR REMOVAL PLACE Hubertson Ave. 4-14-1925

19. UNDERTAKER Mrs. C. S. Forsyth
 (ADDRESS) Kansas City 246

20. FILED P. 29 1931 O. P. Mirand Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 12 - 1925

22. I HEREBY CERTIFY, That I attended deceased from Dec 1 - 1925 to Apr 12 - 1925
 I last saw her alive on Apr 12 - 1925 Death is said to have occurred on the date stated above, at 2:47 m.

The principal cause of death and related causes of importance were as follows:

Acute Dilatation of Heart Date of onset _____

Other contributory causes of importance: Pneumonia

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) E. H. Jones, M. D.

(Address) 80th & Paseo

WRITE PRINTED NAME OF UNDERTAKER IN THIS SPACE

N. B.—Every certificate should be carefully supplied. A statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important.

Supplement

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