

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

Do not use this space.

15151

1. PLACE OF DEATH

County Jackson
Township Raw
City St. Louis

Registration District No. 399
Primary Registration District No. 1007

File No. 2170
Registered No. 2170
St. _____ Ward _____

2. FULL NAME

Lucy S. Keller

(a) Residence, No. 1900 Chelsea 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. 4 How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20 - 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
41 1 29

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) Iowa
(STATE OR COUNTRY)

10. NAME OF FATHER Frank M. Anderson

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

12. MAIDEN NAME OF MOTHER Miss McMillan

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

14. INFORMANT John L. Keller
(Address) 1900 Chelsea

15. FILED 5/30 1925 M. M. Gerome REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1925

17. I HEREBY CERTIFY That I attended deceased from 5-1- 1925, to 5-19- 1925 that I last saw her alive on 5-19- 1925, and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Post operative

Pneumonia
Prolapsus of uterus (duration) _____ yrs. _____ mos. 3 da.

CONTRIBUTORY (SECONDARY) Chronic asthma
(duration) _____ yrs. 1 mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF 5-12-25

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examination by chest findings
Jon Sawyer, M. D.

5700, 1925 (Address) 1701 Jackson

*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 Elmwood DATE OF BURIAL May 21/19 25

20. UNDERTAKER Ross & Co ADDRESS 15 1/2 Jackson

K. E. Ever, 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.

COPYING INK---THIS

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. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. 2170
 City Kansas City (No. _____) St. _____ Ward _____

2. FULL NAME Lucy S. Keller
 (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

3. SEX F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** M
(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)

14. INFORMANT (Address)

15. FILED 5/20 55 M.M. Browe
 REGISTRY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 -19 26

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 _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS: Lobar
Pneumonia
Prothrombin of uterus

CONTRIBUTORY (SECONDARY) Bronchial asthma
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 101A
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

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 **DATE OF BURIAL**

20. UNDERTAKER **ADDRESS**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRATION RECORD
 EXACTLY. PHYSICIANS should state
 OCCUPATION is very important.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.
 FILED 5/20 55 M.M. Browe REGISTRY

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

1915/1

WASHINGTON

1002

13751

Dear Sir:

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:

2170

Name: Lucy S. Keller

Died at: Grace Hosp. K. C. Mo. on May 19-1926

Residence: No. 1908 Chelsea St. _____
(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: Post operative Lobar pneumonia

Prolapsus of uterus. Laceration of Perineum

Contributory: Bronchial Asthma

Was disease contracted? _____

Operation precede death? yes - Date of 5-12-26

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

Name of physician: _____

WRITE PLAINLY

CAUSE OF DEATH

