

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

Do not use this space.

27083

1. PLACE OF DEATH

County Jackson Registration District No. ....

Township Kaw Primary Registration District No. ....

City Kansas City (No. St. Marys Hospital) St. ....

File No. ....

Registered No. 3571 Ward) ....

2. FULL NAME

(a) Residence. No. Nelson Word. ....

(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 Female 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 Fancis M. Newman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 4 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 35 7 15

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work House Wife (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) Missouri

10. NAME OF FATHER James W. Retchey

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

12. MAIDEN NAME OF MOTHER Anna V. Williams

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

14. INFORMANT (Address) Joseph. Retchey 4734 Terrace

15. FILED 9/19 1925 M. M. Crow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-19 1920

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1920, to Sept-19 1920, that I last saw him/her, alive on Sept 14 1920, and that death occurred, on the date stated above, at St. Marys Hospital.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Brain lesion with degeneration  
due to chronic infection of Measles  
17 1/2 (duration) 9 yrs. mos. da.  
CONTRIBUTORY acute dilatation of heart (SECONDARY) (duration) 1 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, .....

DID AN OPERATION PRECEDE DEATH? no DATE OF Sept-14-1920

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chromosome stained (Signed) B. S. Rang, M. D.

Sept 14, 1920 (Address) 1111 Grand ave.

\*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.) Shypp

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Nelson Mo. DATE OF BURIAL 9/20 1920

20. UNDERTAKER P. V. Lindsey & Co ADDRESS 3811 Broadway

N. B.—Every item of information should be carefully supplied in plain terms, so that it may be properly tabulated. Exact statement of OCCUPATION is

# 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 septi emia," "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.

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CERTIFICATE OF DEATH**

**1. PLACE OF DEATH.**

County Jackson Registration District No. \_\_\_\_\_ File No. 27083  
 Township Kansas City Primary Registration District No. \_\_\_\_\_ Registered No. 3674  
 City St. Marys Hosp No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 \_\_\_\_\_ 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 \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 25

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and 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:**

Gallstones with suspected gallbladder fibroid of 10 years duration  
Contributory Cause: Dilatation of heart

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

19. MODE OF DEATH? \_\_\_\_\_  
 PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 TOXIC? \_\_\_\_\_  
 TIME OF DIAGNOSIS? \_\_\_\_\_

(Address) \_\_\_\_\_  
 (In CAUSING DEATH, or in deaths from VIOLENT CAUSES, state NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or on the side for additional space.)

20. AL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

**B. T. SHARP, M. D.**  
 SUITE 636 ARGYLE BLDG.  
 Reg. No. 2377

HOURS: 12 to 3 P. M.  
 Office Phone Victor 4930

RESIDENCE: 3525 CENTRAL  
 Res. Phone Hyde Park 0998

R For \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_

Fibroid was malignant. Was not puerperal.

(Address) \_\_\_\_\_  
 15. FILED 9/19 25 M.M. Corneil 20. UNDERTAKER \_\_\_\_\_  
 REGISTRAR \_\_\_\_\_

ADDRESS \_\_\_\_\_

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

Carefully read and understand the instructions on the reverse side of this certificate. Physicians should state the cause of death in full, and the occupation of the deceased. For certificates until they are complete as prescribed by law. N. B. - F. CAUSE (REGISTRAR) 22

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