

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

8602

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kear Primary Registration District No. 34102 Registered No. _____
 City Kansas City (No. St. Joseph Hospital) St. _____ Ward _____

2. FULL NAME

Florence M. Baker
 (a) Residence. No. St. Francis Hotel (944 W. Holmes) (If nonresident give city or town and State)
 (Usual place of abode) 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>about 60</u>	<u>-</u>	<u>-</u>	<u>-</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Amosias Steeles

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

12. MAIDEN NAME OF MOTHER unknown Bineger

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

14. INFORMANT Robert Baker
 (Address) St. Francis Hotel

15. FICED 9/31 26 m.m. Orwe
 19. _____ REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 30 19 26

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1926, to May 30, 1926, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 2:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute necrosis of stomach
4 1/2 hrs.
 (duration) _____ yrs. _____ mos. _____ ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF May 4
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic ex-
 (Signed) Armed Hill M. D.

*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.)
Mar 31 19 26 (Address) 734 - 1/2 S. 10th St

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Queen's Vaults DATE OF BURIAL Apr - 1 19 26

20. UNDERTAKER New Queen's Sons ADDRESS R. C. Mo

N. B.—Every fact on this certificate 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.

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, Compositor, 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; Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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.

WRITE PLAINLY, WITH UNFADING INK. SUPPLEMENTARY RECORD

N. B.—Do not write in the space for cause of death. It is carefully supplied. Also, do not write in the space for cause of death. It is carefully supplied. Also, do not write in the space for cause of death. It is carefully supplied.

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1 PLACE OF DEATH
 County Jackson REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW
 Township Kear Registration District No. 399 File No. _____
 Village _____ Primary Registration District No. 1005 Registered No. 1353
 City Ke Mo (NO. _____ St. _____ Ward _____)

2 FULL NAME Florence M. Baker

([If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F **4 COLOR OR RACE** Wh **5 SINGLE MARRIED WIDOWED OR DIVORCED** Married
 (Write the word)

6 DATE OF BIRTH _____ 19____
 (Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds.
 If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE
 (City or town, State or foreign country) _____

PARENTS

10 NAME OF FATHER _____
11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____
12 MAIDEN NAME OF MOTHER _____
13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (Address) _____

15 3/23 1928 S.M.M. Brown
 Filed _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3-30-26
 (Month) (Day) (Year)

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:

 (Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY _____
 (Secondary) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ M. D.
 _____ 19____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Cremation **DATE OF BURIAL** 3-23-28

20 UNDERTAKER _____ **ADDRESS** _____

Original file, date 3/31, 1926 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

S-8602

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Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *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), *29ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)