

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

Do not use this space.

15526

1. PLACE OF DEATH

County Buchanan
Township.....
City St. Joseph,

Registration District No. 85
Primary Registration District No. 1001
(No. Missouri Methodist Hospital)

File No. 46
Registered No. 501

2. FULL NAME

Cora May Akers

(a) Residence, No. Gravity, Iowa. St. Gravity, Iowa. 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. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13. 19 26

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

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1926, to May 13, 1926 that I last saw h. or alive on May 12, 1926, and that death occurred, on the date stated above, at 5/50/a m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 3, 1887.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>39</u>	<u>I</u>	<u>I</u>	<u>0</u>	<u>0</u>

Acute Myocarditis with failure of Right Heart.
5/50/a (duration) yrs. mos. 3 ds.

9. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Household
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

CONTRIBUTORY (SECONDARY) Toxic adenoma of thyroid (duration) 17 yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Taylor County, (STATE OR COUNTRY) Iowa.

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

10. NAME OF FATHER William A Brand

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF May 10 WAS THERE AN AUTOPSY?.....

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

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) H. S. Parnell, M. D.

12. MAIDEN NAME OF MOTHER Hattie B McFarlan

May 13 1926 (Address) St Joseph mo.

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

*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.)

14. INFORMANT Oscar Akers (Address) Gravity, Iowa.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gravity, Iowa. DATE OF BURIAL May 14 1926

15. FILED May 13 1926 John G. Webb REGISTRAR

20. UNDERTAKER H. O. Sickenfaden ADDRESS 1802 Union Str

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**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan Registration District No. 857 File No. _____
 Township _____ Primary Registration District No. 1001 Registered No. 501
 City St. Joseph (No. _____) St. _____ Ward _____

2. FULL NAME

Rosa May Akers

(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 ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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.
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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 _____

This was examined microscopically

and was not malignant.

H. S. Conrad, M. D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13 1926

17. I HEREBY CERTIFY, That I attended deceased from _____ 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:

acute myocarditis with failure of right heart
mod malignant
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Toxic adenoma of Thyroid
not malignant
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

PRECEDE DEATH. _____ DATE OF _____

UTOPSY _____

FORMED DIAGNOSIS _____

H. S. Conrad, M. D.
 (Address) St. Joseph, Mo.

* IN CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) whether ACCIDENTAL, SUICIDAL, or (2) whether ACCIDENTAL, SUICIDAL, or (3) whether (state side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

15. FILED 5-13-26 Jahn H. [Signature] REGISTRAR

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