

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

12682
315

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. Old City Hospital)

Registration District No. 300
Primary Registration District No. 2000

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

2. FULL NAME

Marguerite Thomas
(a) Residence. No. 418 1/2 Blaised St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 19 08

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 House work
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas
(STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER Chas Barber

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

12. MAIDEN NAME OF MOTHER Russalie

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

14. INFORMANT Gertrude Giles
(Address) 1316 Euclid

15. FILED 1/22, 1927 M. M. Crane REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-20-1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 1-20-1927, 19____ that I last saw her alive on 1-20-1927, 19____, and that death occurred, on the date stated above, at see a

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Myocarditis
9/10
1/20/27 (duration) _____ yrs. _____ mos. _____ da.
CONTRIBUTORY Pneum. Abscess, Chr. Bronchitis
(SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. M. Smith, M. D.
21, 1927 (Address) Old City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodland Indep. Mo. DATE OF BURIAL 1-23 1927

20. UNDERTAKER Watkins Bros ADDRESS 1729 Lyda

WRITE WITH UNFAD

N. B.—Every 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.

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), 10ds. 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 Jackson Registration District No. _____ File No. _____
 Township _____ Primary Registration District No. _____ Registered No. 315
 City Kansas City, Mo. 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 F. 4. COLOR OR RACE Negro 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, _____ hr. 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) _____

PARENTS

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 1/22 27 M. M. Crowe
 REGISTRAR
West

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20, 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) Proas abscess, tuberculous
Chronic Bronchitis
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____

, 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 _____

WRITE PLAINLY, WITH UNFAIRING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully copyed and should be certified by a physician. PHYSICIANS should state CAUSE OF DEATH in plain words, so that it may be properly classified. Exact statements of cause of death is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-1268

Requested to make _____
cated by check marks, lacking from the death certificate:

Name: Marguerite Thomas
Who died at: Kansas City Mo. on Jan. 20 1927,

Residence: No. _____ 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: Chronic Myocarditis
~~Tuberculosis (non tubercular)~~

Contributory: Psoas abscess (of
T.B. origin) Chronic Bronchitis

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

Was there an autopsy? _____ What ~~last~~ confirmed diagnosis? _____

Name of physician: _____

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S-1268

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