

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

8311

1. PLACE OF DEATH
County Jackson Registration District No. _____
Township Law Precinct Registration District No. _____
City Kansas City (No. St. Mary's Hospital) St. _____ Ward _____

2. FULL NAME Andrew F. Bell
(a) Residence. No. 3207 College St. _____ Ward _____
(Usual place of abode)
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. (If nonresident give city or town and State)

File No. _____
Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 23 = 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
28 11 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) Tool Maker
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Attendale?
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Frank A. Bell

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

12. MAIDEN NAME OF MOTHER Missouri McPeters

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

14. INFORMANT Thurman L. Bell
(Address) Independence, Missouri

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 18 1927

17. I HEREBY CERTIFY That I attended deceased from March 13, 1927, to March 18, 1927 that I last saw him alive on March 18, 1927, and that death occurred, on the date stated above, at 7:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Appendicitis acute perforated Peritonitis

CONTRIBUTORY (SECONDARY) Pneumonia Hypertense
(description) yrs. mos. da. 1 da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: 3207 College

DID AN OPERATION PRECEDE DEATH: yes DATE OF March 13

WAS THERE AN AUTOPSY: no

WHAT TEST CONFIRMED DIAGNOSIS: operative

(Signed) Joel Dunning, M. D.
7/19 1927 (Address) 805 Crumboe Bldg

*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 St. Mary's Cemetery DATE OF BURIAL 3-21 1927

20. UNDERTAKER _____ ADDRESS _____

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important.

Exact statement of OCCUPATION to be stated on first line of certificate

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, meningis, 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 nephritis*, etc. The contributory (secondary or concurrent) affection need not be stated unless important. Example: *Measles* (disease causing death 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, as "Asthenia," "Anemia" (merely symptoms); "Atrophy," "Collapse," "Coma," "Convulsion," "Debility" ("Congenital," "Senile," etc.), "Droop," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Anemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify diseases resulting from childbirth or miscarriage, "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation undertaken. For VIOLENT DEATHS state MANNER OF INJURY and qualify as ACCIDENTAL, SUICIDE, 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 American Medical Association.)

NOTE.—Individual offices may add to above list of undecidable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificate will be returned for additional information which gives the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, metastasis, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will result in vast improvement, and its scope can be extended as a 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
Township N. City
City N. City (No.)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 1163-
St. Ward)

2. FULL NAME

Andrew J. Bell

(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 m 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.

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 3/19, 1927 m. m. Groves REGISTRAR
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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 18 1927

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:

apoplectic stroke perforated peritonitis

CONTRIBUTORY (SECONDARY) Pneumonia Hypostatic Pulmonary Oedema Septicemia

18. WHERE WAS DISEASE CONTRACTED

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

CITY. PHYSICIANS should state AGE should be stated. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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