

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

11869

399

**1. PLACE OF DEATH**

County Jackson Registration District No. 1002 File No. 1005  
 Township Ross Primary Registration District No. Old City Hospital Registered No. 1005  
 City Kansas City (No. Old City Hospital) St. 1005 Ward

**2. FULL NAME**

(a) Residence No. 2416 Merced Ward. Merced  
 (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 Mex 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) child  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF child  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 22-25  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 1 7 29  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work child  
 (b) General nature of industry, business, or establishment in which employed (or employer) child  
 (c) Name of employer

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-21-27 1919  
 17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner 1919 to 1919, and that (that I last saw h. alive on 1919, and that death occurred, on the date stated above, at m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Accidents - Burns  
(Clothes caught fire)

**CONTRIBUTORY (SECONDARY)**

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? Inspection of body  
 (Signed) Deputy Coroner 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.)

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) K. S. Mo.

**10. NAME OF FATHER**

Encenia Arango

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mex

**12. MAIDEN NAME OF MOTHER**

Trinidad Flores

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mex

**14. INFORMANT**

(Address) Mr. Arango  
2416 Merced

**15. FILED**

4/22 27 1919 M. M. Crowe  
Reg REGISTRAR

**19. PLACE OF BURIAL, CREMATION OR REMOVAL**

**DATE OF BURIAL**

W. St. Mary's 4/22 1919

**20. UNDERTAKER**

**ADDRESS**

Katterlin body

PROPERTY OF MISSOURI STATE BOARD OF HEALTH - DO NOT USE THIS SPACE

# 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"); *Labar 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.

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County ..... Registration District No. 399 File No. ....  
 Township ..... Primary Registration District No. 1002 Registered No. 1665  
 City St. Louis City (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE Mex 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr-21 1927  
 17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19....., and that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

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

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Accidental burns clothes caught fire

6. DATE OF BIRTH (MONTH, DAY AND YEAR)  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

Benjamin Curtis Hatcher  
 CONTRIBUTORY (SECONDARY) no burning body

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

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) W. Turner, M. D.  
 21/19 (Address) Dept. of Health

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)

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

15. FILED 4/22 1927 M.M. Crowe REGISTRAR  
act

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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