

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

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.

27196

1. PLACE OF DEATH
 County Jackson Registration District No. _____
 Township Missouri Primary Registration District No. _____
 City Kansas City (No. at Manor Hospital) File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME Michael Henry Davey
 (a) Residence No. Topeka Kan St. 1 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)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 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) April 13-1868

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
60 3 18

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Railroad Conductor
 (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) Ireland

10. NAME OF FATHER Patrick Davey

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

12. MAIDEN NAME OF MOTHER Margaret Davey

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

14. INFORMANT Mrs Michael Davey
 (Address) Topeka Kansas

15. FILED 8/1 28 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/1 19 28

17. I HEREBY CERTIFY That I attended deceased from 3/11 to Aug-1 19 28
 that I last saw him alive on Aug 1 19 28 and that death occurred, on the date stated above, at 1 1/2 R m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
uremia
135
hypochromy, Prostate-retention
 (duration) 3 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Topeka Kansas
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 7-10-28
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
 (Signed) M. J. Owens M. D.
8/1 28 (Address) 818 Realt 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 Topeka Kansas DATE OF BURIAL Aug 3 19 28

20. UNDERTAKER John J. Sheehan ADDRESS K. C. Mo

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, irrespectively 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 employment, it is necessary to know (a) the kind of occupation, (b) the nature of the business or industry, and (c) the place where the work is done. Before an additional line is provided for this purpose, it should be used only when necessary. Examples: (a) *Spinner*, (b) *Cotton mill*, (c) *Grocery*. (a) *Foreman*, (b) *Automobile*. 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, Sewing work 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 years)*. 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: *Typhoid 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) report mere symptoms or terminal ones, as "Asthenia," "Anemia" (merely "Atrophy," "Collapse," "Coma," "Debility" ("Congenital," "Senile," "Exhaustion," "Heart failure," "Hemiplegia," "Marasmus," "Old age," "Mia," "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.)

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.