

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

1 PLACE OF DEATH

County Jackson Registration District No. 388 File No. 31483
 Township Kaw or Primary Registration District No. 1802 Registered No. 3381
 Village or Ward
 City Kansas City, (NO St Lukes Hospital) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jessie Hammond

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH March 29 1 1894
 (Month) (Day) (Year)

7 AGE 47 yrs. 5 mos. 29 ds. IF LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work House Keeping
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Platte les. Mo.

PARENTS

10 NAME OF FATHER Mr. T. L. Hammond

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Platte les. Mo.

12 MAIDEN NAME OF MOTHER Alice S. Johnson

13 BIRTHPLACE OF MOTHER PENNA.

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Sept 28 1931
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased on 9/10 1931, to 9/28 1931, that I last saw her alive on 9/28 1931, and that death occurred, on the date stated above, at 7:50 A. m.

The CAUSE OF DEATH* was as follows:
Peritonitis
12 1/2
18 1/4 (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction
 (Duration) yrs. mos. 9 ds.

(Signed) E. Solity M. D.
9/28 1931 (Address) 1500 Poplarwood Bldg.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Sam Hammond
 (Address) Platte les. Mo.

15 Filed 9-28 1931 M. M. Crave
anon Registrar

(State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted if not at place of death?
 Former or usual residence Platte City Mo

19 PLACE OF BURIAL OR REMOVAL Platte City Mo. DATE OF BURIAL 9-30 1931

20 UNDERTAKER R. F. Rollins ADDRESS Platte City 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, 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 neoplasms); *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*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*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.)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

THIS SUPPLEMENTARY

1. PLACE OF DEATH

County.....
Township.....
City *K. City* (No.....)

Registration District No. *399*
Primary Registration District No. *1002*

File No.....
Registered No. *3981* St..... Ward.....

2. FULL NAME

Jessie Hammond

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

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.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED *9/28* 19*31* *M. M. Leroue* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9/28* 19*31*

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw him alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Peritonitis
Date of onset
Other contributory causes of importance:
Intestinal Obstruction due to post-operative problem

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence or fall in also the following: Accident, suicide or homicide?..... Date of injury....., 19.....

Where did injury occur..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify.....

(Signed) *[Signature]* M. D.
(Address) *[Address]*

SUPPLEMENTARY

S-31488