

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

37880
458

1. PLACE OF DEATH
 County Jackson Registration District No. _____ File No. _____
 Township Leas Primary Registration District No. _____ Registered No. _____
 City Kan City (No. St Joseph Hospital) St. _____ Ward _____

2. FULL NAME Esther Hibbard
 (a) Residence No. 3817 - East 72 St. 12 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 Fe. 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 Edward Hibbard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 21 - 1898

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>32</u>	<u>11</u>	<u>7</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Indiana
 (STATE OR COUNTRY)

10. NAME OF FATHER John Mc Kenzie

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

12. MAIDEN NAME OF MOTHER Mary Barkus

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

14. INFORMANT E. Hibbard
 (Address) 3817 - East 72

15. FILED 4/28 1931 M. M. Crowe
 am REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 28 1931

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1931, to Nov. 28, 1931, that I last saw him alive on Nov. 27, 1931, and that death occurred, on the date stated above, at 37A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Peritonitis
Secondary (duration) yrs. mos. ds. 6
 CONTRIBUTORY Primary streptococcus
 (SECONDARY) infection in uterus (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 1209
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? yes.

WHAT TEST CONFIRMED DIAGNOSIS? Antoxy & Lab.
 (Signed) Scott Jones, M. D.
11/28, 1931 (Address) 802 + Paseo

*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 Burlingame Kan DATE OF BURIAL Nov 29 1931

20. UNDERTAKER J. C. Bergman ADDRESS city

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

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*, *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," "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.

GEO. H. JONES, M. D.

80TH AND PASEO
Office Phone, Jackson 1879

OFFICE HOURS: 2 to 5 p.m.

KANSAS CITY, MO.
Res. Phone, Jackson 1907

R For _____

Date 12/6/31

Address _____

From history and autopsy we were unable to determine the avenue of infection into the uterus. The pregnancy was 6 1/2 months and miscarriage Nov 27th. We would not call it a pyogenic infection since the infection was undoubtedly the cause of the miscarriage. Sent to hospital 11/9 with erroneous diagnosis acute appendicitis - at autopsy appendix normal.

Cause of death - see record in certificate of death.



Service with a Star!

STORE No. 21
80th and Woodland

KANSAS CITY

MISSOURI

Geo. H. Jones

M. D.

U. S. Reg. No. 4806

08873-125

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

4. PLACE OF DEATH

County Jackson
Township Kaw
City Keeno (No. _____)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 4746
St. _____ Ward _____

2. FULL NAME

Esther Hibbard

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ moa. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ moa. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*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 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 _____

Supple

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 11/28 31 771. M. Brown
19 _____ REGISTRAR Wan

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 28 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Primary Streptococcus infection of the tonsils; Cause unknown from history approximately 10 days 18 da.

CONTRIBUTORY (SECONDARY) General Britanitis
(duration) _____ yrs. _____ moa. 8 da.

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. Jones, M. D.

11/26/31, 19 (Address) 804 S. Pass

*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.

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

20. UNDERTAKER _____ ADDRESS _____

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

Every item of information should be carefully classified. Every statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. DEATH in plain terms, so that it is easily understood.

988LE-(2)S