

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

PLACE OF DEATH

County Jackson
Township _____
or
Village _____
or
City Kansas City (NO. 220 East 35th St. _____ Ward)

Registration District No. 399 File No. 17896
Primary Registration District No. 1002 Registered No. 1797

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Joseph S Atchison

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF DEATH May 18, 1911
(Month) (Day) (Year)

DATE OF BIRTH Dec 27, 1856
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 16, 1910, to May 18, 1911, that I last saw him alive on May 13, 1911, and that death occurred, on the date stated above, at 9:30 a.m.

AGE 54 yrs. 4 mos. 21 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1-02

930 Myocarditis
116

BIRTHPLACE (City or town, State or foreign country) Illinois

PARENTS
NAME OF FATHER Thos Atchison ✓
BIRTHPLACE OF FATHER Illinois U.S.
MAIDEN NAME OF MOTHER Kenyon ✓
BIRTHPLACE OF MOTHER U.S.

(Duration) 1 yrs. 2 mos. X ds.
Contributory (SECONDARY) Influenza
(Duration) ___ yrs. ___ mos. 10 ds.

(Signed) Dean Rising M. D.
May 18, 1911 (Address) 65918 St John Ave

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ada Atchison
(ADDRESS) 220 E 35th St.

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

Filed MAY 19 1911 W.D. Wheeler
REGISTRAR

PLACE OF BURIAL OR REMOVAL Springville Mo DATE OF BURIAL 5/20 1911
UNDERTAKER J. J. O'Donnell ADDRESS 1109 1/2

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.

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*, *Compositor*, *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*, *Sar-*

coma, 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 COMPLETED AS PRESCRIBED BY LAW.

CERTIFICATE OF DEATH

County Jackson
 Township _____
 or _____
 Village _____
 or _____
 City Kansas City (NO. 220 East 35th)

Registration District No. 399 File No. 17896
 Primary Registration District No. 1002 Registered No. 17-97
 St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Joseph S. Atchison

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
 (Write the word)
 DATE OF BIRTH Dec. 27, 1856
 (Month) (Day) (Year)
 AGE 54 yrs. 4 mos. 21 ds. If LESS than 1 day, ___ hrs. or ___ min.?
 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Illinois
 NAME OF FATHER Thomas Atchison
 BIRTHPLACE OF FATHER (City or town, State or foreign country) U.S.
 MAIDEN NAME OF MOTHER unknown Kentucky
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) U.S.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Ada Atchison
 (ADDRESS) 220 E. 35 St.

Filed July 6, 1911, H.S. Wheeler
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 18, 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Aug. 16, 1910, to May 18, 1911, that I last saw him alive on May 13, 1911, and that death occurred, on the date stated above, at 9:30 a.m.
 The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) 1 yrs. 2 mos. 6 ds.
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 (Duration) _____ yrs. _____ mos. 10 ds.
 (Signed) Dean S. Rising M. D.
May 18, 1911. (Address) 5918 St Johns Ave

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

PLACE OF BURIAL OR REMOVAL Springville Mo. DATE OF BURIAL 5/20, 1911
 UNDERTAKER J.J. O'Donnell & Co ADDRESS 1109 Bdwr.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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