

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

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

PLACE OF DEATH

County Platte County, Mo.

Township Hansas City, Mo.

Village _____

City _____

Registration District No. 399

Primary Registration District No. 1002

(NO. 1334 S. Paseo Pl. St. _____ Ward _____)

File No. 31615

Registered No. 3163

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

FULL NAME Laura Virginia Tribble

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White MARRIAGE STATUS Widow
(Write the word)

DATE OF DEATH Sept 27th, 1910
(Month) (Day) (Year)

DATE OF BIRTH Feb 26th 1850
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov., 1910, to Sept 27, 1910, that I last saw her alive on Sept 27, 1910, and that death occurred, on the date stated above, at 12 m.

AGE 61 yrs. 7 mos. 1 ds. if LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Filoid Pathosis
23A
120B

OCCUPATION (a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0

(Duration) month yrs. ___ mos. ___ ds.

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

Contributory gastric cancer
(SECONDARY) (Duration) ___ yrs. ___ mos. 12 ds.

NAME OF FATHER Wm. A. White

(Signed) R. E. Blum M. D.
09-28- 1910 (Address) Rice Bldg

BIRTHPLACE OF FATHER (City or town, State or foreign country) Clark Co. Estell Co. Kentucky

MAIDEN NAME OF MOTHER Eliza E. Bryant

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pennsylvania

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A. A. Tribble

Where was disease contracted if not at place of death? _____
Former or usual residence. _____

(ADDRESS) 3681 Madison, St. Mo.

PLACE OF BURIAL OR REMOVAL Edgewood DATE OF BURIAL 9/29, 1910

Filed SEP 28 1910 W. Wheeler REGISTRAR

UNDERTAKER C. Stiney ADDRESS 408 E. 9th
Thos. L. Michel

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) *Salcman*, (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.)

William A. White
Elyse E.

W. A. White



PLACE OF DEATH

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

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

County Jackson Registration District No. 999 File No. Village Kansas City Primary Registration District No. 1002 Registered No. 3163 City (NO. 1334) St. Ward

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

FULL NAME Anna Harmon Tubbs

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED OR WIDOWED OR DIVORCED (Write the word) M DATE OF BIRTH Feb 26 1850 (Month) (Day) (Year) AGE 61 yrs 12 mos 2 ds If LESS than 1 day, hrs or min

DATE OF DEATH 9-27 1911 (Month) (Day) (Year)

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

HEREBY CERTIFY, that I attended deceased from 1910, to 9-27 1911, that I last saw her alive on 9-24 1911, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows: Tubercular Phthisis

BIRTHPLACE (City or town, State or foreign country) City of Kansas

Contributory (Secondary) Tubercular Phthisis (Duration) yrs mos ds

NAME OF FATHER W. J. Tubbs

(Signed) R. J. Sloan M. D. 9-28 1911 (Address) 418 E. 9th

BIRTHPLACE OF FATHER (City or town, State or foreign country) City of Kansas

MAIDEN NAME OF MOTHER Mrs. C. Bryant

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kansas

*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) W. J. Tubbs

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs mos ds. State yrs mos ds.

(ADDRESS) 3681 Madison St.

Where was disease contracted If not at place of death? Former of usual residence.

Filed NOV 6 1911 W. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL Burial DATE OF BURIAL 9-29 1911 ADDRESS 418 E. 9th

Original file, date Sep 28 1911 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health
Association)

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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.)

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