

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 Jackson
Township Kaw
or
Village _____
or
City Kansas City (NO. 912 E 4th St.: _____ Ward)

Registration District No. 399 File No. 31625
Primary Registration District No. 1002 Registered No. 3173

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

FULL NAME May M. C. Stelly

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH Sept 28, 1911
(Month) (Day) (Year)

DATE OF BIRTH Feb 24, 1853
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1911, to Sept 28, 1911,
that I last saw her alive on Sept 25, 1911,
and that death occurred, on the date stated above, at 3:20 p.m.
The CAUSE OF DEATH* was as follows:

AGE 60 yrs. 7 mos. 4 ds. IF LESS than
1 day, ___ hrs. or ___ min.?

Paralysis

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

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

(Duration) 12 yrs. ___ mos. ___ ds.

NAME OF FATHER Jefferson Stelly

Contributory Cerebrals
(SECONDARY) (Duration) ___ yrs. 5 mos. ___ ds.

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

Maiden Name of Mother Catherine Gleaves

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

(Signed) J. H. Swaine M. D.
8/29/11 1911 (Address) 344 O'Harney

*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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ms. G. Broadhurst
(ADDRESS) 912 E. 4 St.

Filed SEP 29 1911 W. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL Oswood DATE OF BURIAL Sept 29, 1911
UNDERTAKER Parisweather & Sons ADDRESS 2120

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.)



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

County Jackson
 Township _____
 or
 Village _____
 or
 City Kansas City

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

Registration District No. 344 File No. _____
 Primary Registration District No. 1002 Registered No. 3173
 No. 912 E. 4 St. St. _____ Ward _____

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

FULL NAME Mary M. C. Wells

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>F.</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>M.</u> <small>(Write the word)</small>	
DATE OF BIRTH <u>July 24 1858</u> <small>(Month) (Day) (Year)</small>			
AGE <u>60 yrs 4 mos 4 ds.</u>		If LESS than 1 day, hrs. or min.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
BIRTHPLACE (City or town, State or foreign country) <u>Mo. Emmet</u>			
PARENTS	NAME OF FATHER <u>William H. Wells</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo. Johnson</u>		
	MARRIED NAME OF MOTHER <u>Elizabeth Wilson</u>		
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo. Johnson</u>			

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>9-28 1911</u> <small>(Month) (Day) (Year)</small>	
HEREBY CERTIFY, that I attended deceased from _____, 1911, to <u>9-28</u> , 1911, that I last saw her alive on <u>9-25</u> , 1911, and that death occurred, on the date stated above, at <u>9:10</u> p.m.	
The CAUSE OF DEATH* was as follows: <u>Paralytic Cigittans</u>	
Contributory <u>Anemia</u> (Secondary) (Duration) yrs. mos. ds.	
(Signed) <u>A. W. Hardisty</u> <u>9-29 1911</u> (Address) <u>344 Hardisty</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. W. W. [unclear]
 (ADDRESS) 912 E. 4 St.
 Filed NOV 17 1911
U. S. Wheeler
 REGISTRAR

*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 St. Mary's DATE OF BURIAL 9-29 1911
 UNDERTAKER Mrs. [unclear] ADDRESS 2120 E. 15 St.

Revised United States Standard Certificate of Death

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

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