

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

N. B.—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.

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

PLACE OF DEATH _____
 County Jackson
 Township _____ Registration District No. 399 File No. 2287
 or _____
 Village _____ Primary Registration District No. 1002 Registered No. 174
 or _____
 City Kansas City (NO University Hospital St. _____ Ward _____) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Amelia Stalling

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
 DATE OF BIRTH Feb 13 1886
 (Month) (Day) (Year)
 AGE 55 yrs. 11 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Saleslady
 (b) General nature of industry, business, or establishment in which employed (or employer) William-Solker

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

PARENTS
 NAME OF FATHER Jos. Marks
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Prussia
 MAIDEN NAME OF MOTHER Unknown
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Prussia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) N. Stalling
 (ADDRESS) 16 + Broadway

Filed JAN 16 1912 TO W. S. Wheeler
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 14, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 12, 1912, to Jan 14, 1912
 that I last saw her alive on Jan 14, 1912
 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:
Post operative shock
from operation for appendicitis
5415
 (Duration) 10 yrs. ___ mos. ___ ds.
 Contributory Washed condition
 (SECONDARY) (Duration) ___ yrs. 3 mos. ___ ds.
 (Signed) Washington M. D.
Jan 15, 1912 (Address) 405 aryle

*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 Cluwood DATE OF BURIAL Jan 16, 1912
 UNDERTAKER Mrs C. L. Forster ADDRESS 18 Brooklyn

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 *Houswife*, *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, peritonaeum*, 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.

PLACE OF DEATH

County Jackson
Township _____
or
Village _____
or
City Kansas City (NO. _____) St.: _____ Ward _____

Registration District No. 399 File No. 1287
Primary Registration District No. 1002 Registered No. 174

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

FULL NAME Amelia Stalling

PERSONAL AND STATISTICAL PARTICULARS

SEX F. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH Feb- 13, 1856
(Month) (Day) (Year)

AGE 55 yrs. 11 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION (a) Trade, profession, or particular kind of work Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer) William - Vaiken

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

PARENTS
NAME OF FATHER Jos. Marks
BIRTHPLACE OF FATHER (City or town, State or foreign country) Prussia
MAIDEN NAME OF MOTHER W. Johnson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Prussia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Stalling
(ADDRESS) 167 Broadway

Filed MAR 8 1912 W.S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 14, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 12, 1912, to Jan. 14, 1912, and last saw her alive on Jan. 4, 1912,

and that death occurred, on the date stated above, at 3a.m.

The CAUSE OF DEATH* was as follows:
Post operative shock
from operation for cystoma
uterine Fibromyoma
(Duration) 10 yrs. ___ mos. ___ ds.

Contributory Weakened condition
(SECONDARY) (Duration) ___ yrs. 3 mos. ___ ds.

(Signed) W.A. Shelton M. D.
Jan 15 1912 (Address) 405 Argyle Bldg.

*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 Elmwood DATE OF BURIAL Jan. 16, 1912
UNDERTAKER Mrs C.L. Foster ADDRESS 918 Brooklyn

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