

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

PLACE OF DEATH

County Jackson

Township J

or

Village

or

City Kansas City (NO. General Hospital St. _____ Ward _____)

Registration District No. 399

Primary Registration District No. 1002

File No. 36236

Registered No. 3635

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

FULL NAME Emil Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If write the word)

Single

DATE OF BIRTH

May 3 1875
(Month) (Day) (Year)

AGE

37 yrs 6 mos 19 ds.

IF LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

5-32

BIRTHPLACE

(City or town, State or foreign country)

Mo.

NAME OF FATHER

Arne Anderson

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

Sweden

MAIDEN NAME OF MOTHER

Dont know

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

Sweden

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Anderson

(ADDRESS)

83 S. 1st St.

NOV 25 1912

W. J. Miller

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Nov 22 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from accident, 1912, to _____, 1912,

that I last saw h _____ alive on _____, 1912,

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

fracture at base of skull
175B

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (SECONDARY)

asphyxiated
(Duration) 2 yrs. 0 mos. 0 ds.

(Signed)

Harry Conlinsky, M.D.
11 25 1912 (Address) 100 S. 1st St.

*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

Woodlawn

DATE OF BURIAL

Nov 25 1912

UNDERTAKER

Daniel Bro

ADDRESS

RCA

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.

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," "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.)

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

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Jackson
Township _____
or _____
Village _____
or _____
City Kansas City (NO. General Hospital St.: _____ Ward) _____

Registration District No. 399 File No. _____
Primary Registration District No. 1002 Registered No. 3635

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

FULL NAME Emil Anderson

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>s.</u>	DATE OF DEATH <u>Nov. 22</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>May 3</u> , 187 <u>5</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>as carrier</u> , 191 <u>1</u> , to _____, 191 <u>1</u> , that I last saw h_____ alive on _____, 191 <u>1</u> , and that death occurred, on the date stated above, at <u>11:30 p.m.</u>	
AGE <u>37</u> yrs. <u>6</u> mos. <u>19</u> ds.			The CAUSE OF DEATH* was as follows: <u>Fracture at base of skull</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Butcher</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>			Contributory <u>Assaulted with club</u> (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>Arne Anderson</u>		(Signed) <u>Harry Garkusky</u> M. D. <u>11/25, 1912</u> (Address) <u>Com. Bldg. S.C.</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Sweden</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER <u>Do not know</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Sweden</u>		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) <u>Chas. Anderson</u>			PLACE OF BURIAL OR REMOVAL <u>Wood lawn</u>	
(ADDRESS) <u>838 So. 8th St.</u>			DATE OF BURIAL <u>Nov 25, 1912</u>	
Filed <u>Nov. 25, 1912</u> <u>W.S. Wheely</u>			UNDERTAKER <u>Daniels Bros.</u>	
JAN 10 1913			ADDRESS <u>W. C. K.</u>	
REGISTRAR				

Original file. date. OV : _____, 19____ 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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