

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

Sarah L. Skiff

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

PLACE OF DEATH
 County Jackson
 Township Frank Registration District No. 399 File No. 1200
 or Village _____ Primary Registration District No. 1092 Registered No. 24
 or City Kansas City, Mo. NO. 2535 Brooklyn St. _____ Ward _____
 FULL NAME Sarah Elizabeth Skiff (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept 7, 1827
 (Month) (Day) (Year)

AGE 85 yrs. 3 mos. 25 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
 NAME OF FATHER Harold Mayhue
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Maine
 MAIDEN NAME OF MOTHER Margia Allen
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Maine

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 1, 1913
 (Month) (Day) (Year) 13

I HEREBY CERTIFY, that I attended deceased from Jan 30, 1912, to Dec 30, 1912
 that I last saw her alive on Dec 30, 1912
 and that death occurred, on the date stated above, at 6:15 a.m.
 The CAUSE OF DEATH* was as follows:
Epithelioma
50
162

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Senility
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. J. Skiff M. D.
Jan 1, 1913 (Address) 622 Second 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Holmes Churchhill
 (ADDRESS) 2535 Brooklyn Ave

JAN 2 1913
 Filed _____ 1913 W. S. Wheeler REGISTRAR

PLACE OF BURIAL OR REMOVAL Furtt Hill DATE OF BURIAL Jan 2, 1913
 UNDERTAKER John W. Wagner ADDRESS 1709 Grand Ave

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) *Colton 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 "Asthensia," "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 RE-BUREAU OF VITAL STATISTICS
 CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CERTIFICATE OF DEATH

PLACE OF DEATH
 County Jackson
 Township _____
 or
 Village _____
 or
 City Kansas City (NO. 2535 Brooklyn St.; _____ Ward)

Registration District No. 399 File No. _____
 Primary Registration District No. 1002 Registered No. 24

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

FULL NAME Sarah L. Skiff

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED widowed
 WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH Sept. 7, 1827
 (Month) (Day) (Year)
 AGE 85 yrs. 3 mos. 25 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
 NAME OF FATHER Harior Payne
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Maine
 MAIDEN NAME OF MOTHER Maggie Allen
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Maine

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Holmes Churchill
 (ADDRESS) 2535 Brooklyn Ave.

Filed MAR -7 1913 1913 W.S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 1, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 30, 1912, to Dec. 30, 1912, that I last saw her alive on Dec. 30, 1912, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:
Epithelioma of the breast.

Duration) _____ yrs. _____ mos. _____ ds.

Contributory Senility
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. J. Kopf M. D.
Jan. 1, 1913 (Address) Cor. SW. Blind

*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 Forest Hill DATE OF BURIAL Jan. 2, 1913

UNDERTAKER John W. Wagner ADDRESS 1209 Grand

Original file, date JAN 2 1913, 19____. All information called for must be written on this Supplementary Card.

Revised United States Standard Certificate of Death

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

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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 "*Asihemia*," "*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 septichaemia*," "*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.)

0021