

PLACE OF DEATH

County

Jackson

Township

Kaw

Village

Kansas city

City

9.2462 ✓

Registration District No. 999

Primary Registration District No. 1002

File No.

Registered No.

1195

185

(NO. 3220 Oak St. Ward)

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

FULL NAME

Miss Emma Basse

PERSONAL AND STATISTICAL PARTICULARS

SEX Female	COLOR OR RACE White	SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)
DATE OF BIRTH Oct 7, 1887 (Month) (Day) (Year)		
AGE 26 yrs. 3 mos. 7 ds.		IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

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

House Work

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

None

BIRTHPLACE

(City or town, State or foreign country)

Mo

NAME OF FATHER

C. E. Basse

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Germany

MAIDEN NAME OF MOTHER

Louise Jansen

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs R E Flynn

(ADDRESS)

2640 Norton

JAN 16 1914

Filed

191

W. S. Wheeler

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 14, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 10th, 1913, to Jan 14, 1914, that I last saw her alive on Jan 14, 1914, and that death occurred, on the date stated above, at 12:06 p.m.

The CAUSE OF DEATH* was as follows:

Obesity, and fibric inflammation operated on the 12th, rendering one kidney and appendix, and breaking up albumen of the blood (Duration) 6 yrs. mos. ds.

Contributory

Surgical shock ✓

(Duration) yrs. mos. 2 ds.

(Signed)

B. E. Dawson

M. D.

(Address) 3220 Oak 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

Forest Hill

DATE OF BURIAL

Jan 16, 1914

UNDERTAKER

C. J. Foster

ADDRESS

918 Brooklyn

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, 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, 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.)

PLACE OF DEATH

County _____

Township _____

or
Village _____or
City KANSAS CITYREGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATED
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 399

File No. _____

Primary Registration District No. 1002Registered No. 185(NO. 3270 Oak St.: _____ Ward)[If death occurred in a
hospital or institution,
give its NAME instead
of street and number]FULL NAME Emma Bosse

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX _____ COLOR OR RACE _____ SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF DEATH _____, 191____
(Month) (Day) (Year)DATE OF BIRTH _____, 1____
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from
_____, 191____, to _____, 191____,AGE _____ yrs. _____ mos. _____ ds. If LESS than
1 day, _____ hrs
or _____ min.that I last saw h. _____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.OCCUPATION
(a) Trade, profession, or
particular kind of work _____
(b) General nature of industry,
business, or establishment in
which employed (or employer) _____

The CAUSE OF DEATH was as follows:

BIRTHPLACE
(City or town,
State or foreign country) _____Ovaritis and Pelvic Inflammation
Operation - removal of one ovary
and Appendix Chronic Ovaritis & Endometritis
External adhesion of the uterus
(Duration) 4 yrs. _____ mos. _____ ds.

NAME OF FATHER _____

Contributory Surgical Shock
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____(Signed) B. E. Dawson M. D.
_____, 191____ (Address) 3220 Oak St.

MAIDEN NAME OF MOTHER _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS) Home of Residence
At place of death _____ yrs. _____ mos. _____ ds. *In the
State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted? I Do not know
If not at place of death? _____

(Informant) _____

Former or usual residence I left school & had no other res.

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

Filed _____, 191____

UNDERTAKER _____ ADDRESS _____

REGISTRAR

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Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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