

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 Buchanan ✓
Township Washington (Outside) Registration District No. 86 File No. 31581
or
Village _____ Primary Registration District No. 5127 Registered No. 67
or
City St. Joseph (NO. Woodson Sanitarium St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]
FULL NAME John Joseph Cummings

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE—
MARRIED Married
WIDOWED
OR DIVORCED
(Write the word)
DATE OF BIRTH July 23, 1881
(Month) (Day) (Year)
AGE 33 yrs. 3 mos. 5 ds. If LESS than
1 day, ___ hrs.
or ___ min.?
OCCUPATION
(a) Trade, profession, or
particular kind of work Bartender
(b) General nature of industry,
business, or establishment in
which employed (or employer) C. F. Ogden
BIRTHPLACE
(City or town,
State or foreign country) Leavenworth, Kans
PARENTS
NAME OF FATHER Dennis Cummings
BIRTHPLACE
OF FATHER
(City or town, State or foreign country) London
MAIDEN NAME
OF MOTHER Catherine Callahan
BIRTHPLACE
OF MOTHER
(City or town, State or foreign country) Kansas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Michael Cummings
(ADDRESS) Leavenworth, Kans

Filed Oct 29, 1914 Assume Terry
10 exp. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October 29, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Oct 29, 1914, to Oct 29, 1914
that I last saw him alive on Oct 28, 1914,
and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Endocarditis

91A
(Duration) 3 yrs. 3 mos. 3 ds.

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

(Signed) St Joseph 1002709 M. D.
Oct 30, 1914 (Address) 215 Woodson

*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 1 yrs. 1 mos. 1 ds. In the State 5 yrs. 1 mos. 1 ds.

Where was disease contracted 916 North 20th St
if not at place of death?
Former or usual residence 916 North 20th Street

PLACE OF BURIAL OR REMOVAL Leavenworth, Ks DATE OF BURIAL Oct 30, 1914

UNDERTAKER H. C. Lindenfelder ADDRESS 215 No. 10th St

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.)

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

PLACE OF DEATH
County Buchanan
Township Washington
or
Village
or
City _____ NO. _____

Registration District No. 86 File No. _____
Primary Registration District No. 5127 Registered No. 67
St. _____ Ward _____

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

FULL NAME

John Joseph Cummings

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W
SINGLE MARRIED WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day, _____ hrs. or _____ min.

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(ADDRESS) _____

Filed Dec 2 1914 Jannie George
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 29, 1914
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the date _____, at _____ m. The CAUSE OF DEATH* was as follows:

Endocarditis Acute
(Duration) _____ yrs. _____ mos. 1 or 2 ds.

Contributory Exhaustion
(SECONDARY) best known (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Ch. Houston M. D.
Oct 30 1914 (Address) 220 N 10th

*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 12 hours In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted best known
If not at place of death _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

OCT 29 1914

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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