

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

PLACE OF DEATH

County Jackson

Township _____

or Village _____

or City Kansas City (No. _____)

City Kansas City (No. _____)

Registration District No. 399

Primary Registration District No. 1002

File No. 35476

Registered No. 3411

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

FULL NAME Maggie Ward

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Col SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Nov. 10, 1914
(Month) (Day) (Year)

DATE OF BIRTH April 15, 1875
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1 - 1914 to Nov 10, 1914, that I last saw her alive on Nov 9, 1914, and that death occurred, on the date stated above, at 7:30 a.m. The CAUSE OF DEATH* was as follows:

AGE 39 yrs. 5 mos. 26 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

Uraemia (Kidney stone)

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

13 1/2 (Duration) yrs. mos. 3 ds. Contributory: Kidney stone (SECONDARY) (Duration) 6 yrs. mos. ds.

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

NAME OF FATHER Sam Mankins

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

MAIDEN NAME OF MOTHER Elvira Needy

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

(Signed) 11/10/14 Wesley Faust M. D. Nov. 10, 1914 (Address) 200 Wabasha Bldg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) Newton Ward

At place of death ___ yrs. ___ mos. 8 ds. In the State ___ yrs. ___ mos. 8 ds.

(ADDRESS) 540 State K.C. Mo

Where was disease contracted If not at place of death? St. Joseph Hosp.

Filed NOV 12 1914 M.S. Wheeler

Former or usual residence Kansas City Mo.

PLACE OF BURIAL OR REMOVAL Versailles Mo DATE OF BURIAL Nov 16, 1914

UNDERTAKER N.W. Thatcher ADDRESS 1374 N 5th

REGISTRAR

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.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

County

Township

Registration District No.

File No.

Village

Primary Registration District No.

Registered No.

City Kansas City (NO. 399) St. 3rd Ward 3411

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MCOLOR OR RACE BSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) M

DATE OF DEATH

(Month)

(Day)

1914
(Year)

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

yrs.

mos.

ds.

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

I HEREBY CERTIFY, that I attended deceased from _____, 1914, to _____, 1914, that I last saw h. _____ alive on _____, 1914, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

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)

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

1914

REGISTRAR

Contributory

(SECONDARY)

(Signed)

1914

(Duration)

yrs.

mos.

3 ds.

(Duration)

yrs.

mos.

ds.

(Address) Kansas City, Mo.

*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:

DATE OF BURIAL

1914

UNDERTAKER

ADDRESS

Original file, date NOV 1914 All information called for must be written on this Supplementary Certificate.

CAUSE OF DEATH IN Plain terms, so that it may be properly classified. Exact statement of OCCUPATION, if any.

Satisfactory Information Supplied. SUPPLEMENTARY CERTIFICATE

Satisfactory Information Supplied. SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

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