

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

PLACE OF DEATH

County Jackson

Township Kaw

Village _____

City Kansas City

Registration District No. _____

File No. 8836

Primary Registration District No. 1002

Registered No. 1108

(No. 1103 Cherry St. St.: _____ Ward)

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

FULL NAME Ollie M. Bryant.

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
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DATE OF DEATH March 26, 1915
(Month) (Day) (Year)

DATE OF BIRTH Sept. 4, 1880
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 21, 1915, to March 26, 1915;
that I last saw her alive on March 26, 1915,
and that death occurred, on the date stated above, at 9.30 P.
The CAUSE OF DEATH* was as follows:
Pneumo

AGE 34 yrs. 6 mos. 22 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) _____

1074
186A
194B (Duration) _____ yrs. _____ mos. 3 ds.

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

PARENTS	NAME OF FATHER <u>John Wheeler</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Georgia</u>
	MAIDEN NAME OF MOTHER <u>Louise Coe</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>

Contributory Injury to spine in a fall
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) William Thompson M. D.
March 28, 1915 (Address) 838 Pratt 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
(Informant) Loren E Bryant
(ADDRESS) 1103 Cherry St

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 7 yrs. _____ mos. _____ ds. In the Life-time State yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? Residence
Former or usual residence 1103 Cherry St.

Filed MAR 29 1915 1915 W.S. Wheeler
REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Elmwood</u>	DATE OF BURIAL <u>March 30, 1915</u>
UNDERTAKER <u>Our Newcomer's Sons</u>	ADDRESS <u>2111 E 9th St.</u>

N. B.—Every item of information should be carefully checked for accuracy. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each 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 most 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, peritonaeum*, 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.)

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

County _____

Township _____ or Village _____ or City Kansas City

Registration District No. 399 File No. _____

Primary Registration District No. 1002 Registered No. 1108

St. _____ Ward _____

FULL NAME Ellie M. Bryant

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>M</u> (Write the word)
DATE OF BIRTH _____		If LESS than 1 day, _____ hrs or _____ min
AGE _____ yrs. _____ mos. _____ ds.		
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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 26, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory Injury to spine in a fall
(SECONDARY) cause unknown
(Duration) _____ yrs. 4 mos. _____ ds.

(Signed) William Thompson M. D.
Mar 28, 1915 (Address) 831 Riata

*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) _____

(ADDRESS) _____

Filed 3/29 1915 W. S. Wheeler
REGISTRAR

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

SUPPLEMENTARY

Supplied. AGE should be stated EXACTLY. PHY

Revised United States Standard Certificate of Death

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

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