

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

1 PLACE OF DEATH

County Jackson
Township Kaw or Village Kansas City (No. St. Lukes Hospital St. Ward) 93
Registration District No. 399 File No. 1501
Primary Registration District No. 1002 Registered No.

2 FULL NAME Nellie Ferguson.

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Married</u>
6 DATE OF BIRTH <u>May</u> <u>1</u> , 18 <u>56</u> (Month) (Day) (Year)		
7 AGE <u>59</u> yrs. <u>6</u> mos. <u>6</u> ds.		IF LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House-wife</u> <u>4 1/2</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>123</u>		
9 BIRTHPLACE (City or town, State or foreign country) <u>Ill.</u>		
PARENTS	10 NAME OF FATHER <u>Harrison Dye</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Indiana</u>	
	12 MAIDEN NAME OF MOTHER <u>Sarah Pope</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Indiana</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jan. 7, 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 1, 1916, to Jan 7, 1916, that I last saw her alive on Jan 6, 1916, and that death occurred, on the date stated above, at 5:05 a. m.

The CAUSE OF DEATH* was as follows:

Heart stops with for valv
malfunction

CONTRIBUTORY (Secondary) Hypostatic pneumonia
(Duration) 1 yrs. mos. ds.
(Signed) H. D. Breyfogle M. D.
1-7, 1916 (Address) 31 1/2nd Indiana

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 24 ds. In the 30 yrs. mos. ds.

Where was disease contracted if not at place of death? 1006 Cleveland

Former or usual residence

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. S. Ferguson
(Address) 1006 Cleveland

15 Filed JAN 9 1916 Paul Payne Registrar

19 PLACE OF BURIAL OR REMOVAL Mt. Washington DATE OF BURIAL Jan. 9, 1916

20 UNDERTAKER Burton's Sons ADDRESS 2111 E 9th

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 is sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Architect*, *Locomotive engineer*, *Civil engineer*, *fireman*, etc. But in many cases, especially in employments, it is necessary to know (a) the work and also (b) the nature of the business or occupation and therefore an additional line is provided for statement; it should be used only when needed. Examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Store*; (a) *Foreman*, (b) *Automobile factory*. The occupation worked on may form part of the second statement; never return "Laborer," "Foreman," "Manager," etc., without more precise specification, as *Day laborer*, *Laborer—Coal mine*, etc. Women who are engaged in the duties of the household should be reported 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," "Uræmia," "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.)