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

1 PLACE OF DEATH

County: Jackson

Township: Kaw or Village: or City: Kansas (No. 4021 Prospect St.; Ward)

Registration District No. 899 — File No. 28094

Primary Registration District No. 1002 — Registered No. 2430

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

2 FULL NAME: Mr Geo. W. Willis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): single

6 DATE OF BIRTH: Sept 4, 1859 (Month, Day, Year)

7 AGE: 56 yrs. 11 mos. 21 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Pensioned 85
(b) General nature of industry, business, or establishment in which employed (or employer): Fireman 1 2 3

9 BIRTHPLACE (City or town, State or foreign country): Sparta Co. Canada

PARENTS

10 NAME OF FATHER: Geo Willis

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Doublin Ireland.

12 MAIDEN NAME OF MOTHER: Miss Charlotte Disher.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Ada Willis
(Address): 4021 Prospect

15. Rec'd 1916, 191 — Filed AUG 2 1916, 191 — Chas H Miller, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 25, 1916 (Month, Day, Year)

17 I HEREBY CERTIFY, that I attended deceased from July 11, 1916, to Aug 25, 1916, that I last saw him alive on Aug 25, 1916, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:
Protracted Pain in head & epilepsy
Head failure and exhaustion
Date number of attack during day & previous night very most from previous attack (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Nerve complete exhaustion abolis / Renal's asthma
Intestinal Neurosis (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) W. N. Crowder M. D.
Aug 26, 1916. (Address) 63 Woodland

*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. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Elmwood — DATE OF BURIAL: 1, 1916

20 UNDERTAKER: Eylar Bros. — ADDRESS: 1401 Main St

CAUSE OF DEATH in plain words. GIVE should be stated EXACTLY. PHYSICIAN should be classified. Exact statement of OCCUPATION

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, 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 *septichaemia*," "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.)

H. P. 890 E. W. H. Crowder 637 Woodland.

N. B.—Every item of information should be carefully supplied. A AGE should be stated EXACTLY. VISICIANS should state CAUSE OF DEATH in [illegible] the proper [illegible] classified. Exact statement of OCCUPAN is very important.

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

1 PLACE OF DEATH

County .....

Township .....
or
Village .....
or
City Kansas City (NO. 4021 Prospect St.; ..... Ward)

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

Registration District No. 399 File No. .....

Primary Registration District No. 1002 Registered No. 2930

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

2 FULL NAME Geo. W. Willis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 Filed Aug 27, 1916 Thos. F. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 25 (Day), 1916 (Year)

17 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 ..... m.

The CAUSE OF DEATH* was as follows:

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

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

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Belmwood

DATE OF BURIAL 8-27, 1916

20 UNDERTAKER Eylar Bros

ADDRESS 1401 Main St

SUPPLEMENTARY

Satisfactory Information Supplied.

Original file, date AUG 1916, 19.....

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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