

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

1175

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township New Primary Registration District No. 1002 Registered No. 7197
 City Farmacia City (No. 4924 Troostwood Rd. St. _____ Ward)

2. FULL NAME

Mrs. Sevilla Given
 (a) Residence. No. 4924 Troostwood Rd. St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 16 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 3 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>7</u>	<u>9</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Knox Co., Ohio
 (STATE OR COUNTRY)

10. NAME OF FATHER Richard House

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Dickson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT Mr. A. F. Cochran
 (Address) 4924 Troostwood Rd.

15. FILED 1/5 23 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 12 1923

17. I HEREBY CERTIFY, That I attended deceased from Aug 1922 to Jan 12 1923 that I last saw him/her alive on Jan 12 1923, and that death occurred, on the date stated above, at 845 P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
 (duration) yrs. 6 mos. da. _____

CONTRIBUTORY (SECONDARY) Endocarditis Chronic
 (duration) yrs. 6 mos. da. _____

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, Kennett Mo.

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Blood analysis
 (Signed) H. H. Lusk, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)
 Address 824 Rialto Bldg

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Belton Mo. DATE OF BURIAL 1/15 1923

20. UNDERTAKER A. W. Jewcomer's Sons ADDRESS R. C. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD SIGN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH

County

Jackson

Township

Village

Kansas City

City

(No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of

Registered No.

191

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

2 FULL NAME

Mrs Sevilla Lisen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

F

4 COLOR OR RACE

W

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

W

6 DATE OF BIRTH

June 3, 1857
(Month) (Day) (Year)

7 AGE

68 yrs. 7 mos. 9 ds. or 1 day, 2 hrs. 9 min. ?
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

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature)

(Address)

15

15 1923 M. M. Brown
REGISTRAR

15 DATE OF DEATH

Jan 12, 1923
(Month) (Day) (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

DATE OF BURIAL

, 191

20 UNDERTAKER

ADDRESS

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," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

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