

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

5262

399

1. PLACE OF DEATH

County Jackson Registration District No. 1002 File No. _____
 Township Kaw Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. 122) Campbell St. _____ Ward) _____

2. FULL NAME

Chas Thomas
 (a) Residence. No. 722 Campbell Ward. _____
 (Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1872

7. AGE YEARS 57 MONTHS ✓ DAYS ✓ IF LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Comm. Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mayview
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not Known
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Kittie Thomas

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

14. INFORMANT Alice Lawson
 (Address) 722 Campbell St.

15. FILED 2/27/23 1923 M.M. Crowl
 REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 24 1923

17. I HEREBY CERTIFY: That I attended deceased from Feb 21 - 1923 to Feb 24 - 1923 that I last saw him alive on Feb 23 - 1923, and that death occurred, on the date stated above, at 5:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
108
 (duration) X yrs. X mos. 4 ds.

CONTRIBUTORY (SECONDARY) nothing
 (duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) O. H. Henderson, M.D.

2-26-23 (Address) 902 Indep.

*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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Independence, Mo. DATE OF BURIAL Feb. 27, 1923

20. UNDERTAKER Adkins Brothers ADDRESS 2122 Vine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

2 30

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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *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 symptomatic), "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.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

M. D.—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. See instructions on back of certificate.

1 PLACE OF DEATH

County Jackson
 Township _____
 Village or City Kansas City (No. _____) St.; _____ Ward _____

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of _____

Registered No. 974

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

2 FULL NAME Chas Thomas
722 Main St

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M

4 COLOR OR RACE N

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

16 DATE OF DEATH Feb 24, 1923
 (Month) (Day) (Year)

6 DATE OF BIRTH X Unknown, 1875
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

7 AGE 57 yrs. X mos. X ds. or X mla. ?
 If LESS than 1 day, ____ hrs.

that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

8 OCCUPATION

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

The CAUSE OF DEATH* was as follows:

9 BIRTHPLACE (State or country) _____

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

PARENTS

10 NAME OF FATHER _____

Contributory (SECONDARY) _____

11 BIRTHPLACE OF FATHER (State or country) _____

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

12 MAIDEN NAME OF MOTHER _____

(Signed) _____, M. D.

13 BIRTHPLACE OF MOTHER (State or country) _____

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

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted, If not at place of death? _____

(Informant) _____

Former or usual residence _____

(Address) _____

19 PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

15 Filed 27 1923

20 UNDERTAKER _____

ADDRESS _____

M. M. Crow
 REGISTRAR

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