

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

399

33006

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City Kansas city, mo (No. Old City Hospital)

Registration District No. 1002  
Primary Registration District No. Old City Hospital

File No. 4240  
Registered No. 4240 St.          Ward         

**2. FULL NAME**

Frank Brown  
(a) Residence. No. 2316 Campbell St. A Ward           
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Marchie Brown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 17 - 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
62                      11                      2

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**10. NAME OF FATHER**

Frank Brown

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**12. MAIDEN NAME OF MOTHER**

Unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**14.**

INFORMANT Marchie Brown  
(Address) 2316 Campbell St.

**15.**

FILED 11/6 1923 M. M. Cerewe  
Dy REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 2 19 23

17. I HEREBY CERTIFY, That I attended deceased from 10-27 1923 to 11-2 1923 that I last saw him alive on 11-2 1923, and that death occurred, on the date stated above, at 8:30 PM m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Amyloid  
82 A  
97

CONTRIBUTORY (SECONDARY) Arteriosclerosis (duration) 6 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? 9/13

DID AN OPERATION PRECEDE DEATH? no DATE OF 11-2-23

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Smear data, lab findings

(Signed) L. W. Roake, M.D.  
Nov. 3, 1923 (Address) Old City Hospital

\*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**

DATE OF BURIAL

Maple Hill Cemetery 11-6 1923

**20. UNDERTAKER**

ADDRESS

West, Appt. James 1600 E 19 St.

N. B.—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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

# 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, 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 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.

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

1. PLACE OF DEATH  
 County Jackson Registration District No. 399 File No. 33006  
 Township Kansas City Primary Registration District No. 1002 Registered No. 4296  
 City Old City Hosp Sl.                      Ward                     

2. FULL NAME Frank Brown  
 (a) Residence. No. 2316 Campbell St.                      Ward.                       
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF                       
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 17 - 1861  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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

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

10. NAME OF FATHER                       
 11. BIRTHPLACE OF FATHER (CITY OR TOWN)                       
 (STATE OR COUNTRY)                       
 12. MAIDEN NAME OF MOTHER                       
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)                       
 (STATE OR COUNTRY)                     

14. INFORMANT                       
 (Address)                     

15. FILED 11/6 19 24 M. M. Terove  
04 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 2 19 23

17. I HEREBY CERTIFY, That I attended deceased from                      to                     , 19 23, that I last saw h.                      prior to                     , 19 23, and that death occurred, on the date stated above, at                     .

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apoplexy  
                     (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Atherosclerosis  
                     (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED                       
 IF NOT AT PLACE OF DEATH                       
 DID AN OPERATION PRECEDE DEATH no DATE OF Nov 23

WAS THERE AN AUTOPSY                       
 WHAT TEST CONFIRMED DIAGNOSIS                       
 (Signed)                     , M. D.  
 , 19 23 (Address)                     

\*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                      DATE OF BURIAL                      19 23

20. UNDERTAKER                      ADDRESS                     

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

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BY PHYSICIAN

*No operation*