

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

Do not use this space.

11877

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kear Primary Registration District No. _____
City Kansas City (No. 7412 to 134) St. _____ Ward _____

File No. _____
Registered No. 1305
St. _____ Ward _____

2. FULL NAME

Josephine Mildred Sexton
(a) Residence No. 7412 - E - 134 St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
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 Fe. 4. COLOR OR RACE White 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) Jan 2, 1919

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 4 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(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) Wash. Mo.

10. NAME OF FATHER Arthur Sexton

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

12. MAIDEN NAME OF MOTHER Ernie Harmon

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

14. INFORMANT (Address) Arthur Sexton
7412 E. 134

15. FILED 4/1 24 m. m. Keroue REGISTRAR
29

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 1 1924

17. I HEREBY CERTIFY That I attended deceased from March 25 1924 to Apr 1 1924 that I last saw her alive on Apr 1 1924 and that death occurred, on the date stated above, at 7-45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Whooping cough
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. W. Martin M. D.

4/2 1924 (Address) 6800 Wash. Pl. Blvd.

*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

Cresting Cem Apr 3 1924

20. UNDERTAKER ADDRESS

Mrs. L. S. Sexton 15. 16. W. P.

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
of each and every person, irrespec-
many occupations a single word or
line will be sufficient, e. g., *Farmer or
an, Compositor, Architect, Locomo-
tive Engineer, Civil Engineer, Stationary Fireman, etc.* But in many cases, especially in industrial employ-
ments, 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) Sales-
man, (b) Grocery; (a) Foreman, (b) Automobile fac-
tory.* The material worked on may form part of the
second statement. Never return "Laborer," "Fore-
man," "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 occu-
pation at beginning of illness. If retired from busi-
ness, that fact may be indicated thus: *Farmer (re-
tired, 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; Broncho-
pneumonia* ("Pneumonia," unqualified, is indefinite);
*Tuberculosis of lungs, meninges, peritoneum, etc.,
Carcinoma, Sarcoma, etc., of.....* (name orig-
in; "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 in-
tercurrent) affection need not be stated unless im-
portant. 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," "Convul-
sions," "Debility" ("Congenital," "Senile," etc.),
"Dropsy," "Exhaustion," "Heart failure," "Hem-
orrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uremia," "Weakness," etc., when a
definite disease can be ascertained as the cause.
Always qualify all diseases resulting from child-
birth 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 rail-
way 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 undesir-
able terms and refuse to accept certificates containing them.
Thus the form in use in New York City states: "Certificate,
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, hemor-
rhage, 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.