

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

✓ 189

1. PLACE OF DEATH
 County Buchanan Registration District No. 1002
 Township St. Joseph Primary Registration District No. 1002
 City St. Joseph (No. 1002 Hospital) St. _____ Ward _____

2. FULL NAME Blanche B. Burdick
 (a) Residence. No. King City Mo. St. Ward King City Mo.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 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) Year 1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
29

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) Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Jefferson Ball
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Alice Ross
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT H. S. Cole
 (address) King City, Mo.

15. FILED JAN 7 1927
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 6, 1927, to Jan 7, 1927
 that I last saw her alive on Jan 7, 1927, and that death occurred, on the date stated above, at 7: 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Paralytic illness
following laparotomy for
internal fibroma
5 1/2 (duration) yrs. mos. 2 ds.
 CONTRIBUTORY Wernic myopathy
 (SECONDARY) Unknown
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED King City Mo
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? yes DATE OF Jan 6 - 27
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) John P. Byrne, M. D.
 (Address) 17 1/2 1927 Corby Bldg.

*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 King City Mo DATE OF BURIAL 1/9 1927

20. UNDERTAKER Rock Funeral Home ADDRESS 98 S. Lorraine

PERMANENT RECORD

N. B.—Every item or 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.

FEB 22 1927

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 neoplasm); *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), 10ds. 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**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Buchanan Registration District No. 85 File No. _____
 Township _____ Primary Registration District No. 1001 Registered No. 25
 City St. Joseph (No. _____) Sl. _____ Ward _____

2. FULL NAME Blanche E. Burdick

(a) Residence. No. _____ 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 F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) W

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

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

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7, 1937

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralytic ileus following hysterectomy for uterine fibroids
 (duration) _____ yrs. _____ mos. 2 ds.
CONTRIBUTORY (SECONDARY) Uterine myoma
now insignificant
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH. 139 DATE _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) John W. Byrne, M.D.
 _____, 19____ (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.)

14. INFORMANT (Address) _____

15. FILED 7-22-27 John W. Byrne REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ **DATE OF BURIAL** _____ 19____

20. UNDERTAKER _____ **ADDRESS** _____

SUPPLEMENTARY

N. B.: CAUSE OF DEATH SHOULD BE WRITTEN EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important.
 WRITE FULLY, WITH UNFADING INK, IN WHICH CASE IT IS A PERMANENT RECORD.
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