

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.

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | | |
|---|--|--|---|--|--|
| PLACE OF DEATH County <u>Callaway</u> | | | MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH | | |
| Township _____ or _____ Village _____ or _____ City <u>Pultons</u> | | | Registration District No. <u>104</u> Primary Registration District No. <u>3008</u> (NO. <u>State Hospital</u> St. <u>9</u> Ward) | | |
| FULL NAME <u>Edith Painter</u> | | | File No. <u>29932 169</u> Registered No. <u>101 169</u> | | |
| SEX <u>Female</u> | | | DATE OF DEATH <u>Oct. 15, 1910</u> (Month) (Day) (Year) | | |
| COLOR OR RACE <u>White</u> | | | I HEREBY CERTIFY, that I attended deceased from <u>Jan 11, 1910</u> to <u>Oct 14, 1910</u> , that I last saw her alive on <u>Oct 14, 1910</u> , and that death occurred, on the date stated above, at <u>2:25</u> p. m. | | |
| SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OR DIVORCED <input type="checkbox"/> (Write the word) <u>yes</u> | | | The CAUSE OF DEATH* was as follows: <u>Epilepsy</u> <u>85</u> (Duration) <u>7</u> yrs. <u>4</u> mos. _____ ds. | | |
| DATE OF BIRTH <u>Jan 4, 1910</u> (Month) (Day) (Year) | | | Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds. | | |
| AGE <u>19</u> yrs. <u>4</u> mos. <u>11</u> ds. If LESS than 1 day, _____ hrs. or _____ min.? | | | (Signed) <u>R. S. Magee</u> M. D. <u>10/15</u> 1910 (Address) <u>Pultons MO</u> | | |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>house work</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Stoutsville Mo</u> | | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State <u>19</u> yrs. _____ mos. _____ ds. | | |
| PARENTS | NAME OF FATHER <u>Geo O. Painter</u> | | Where was disease contracted? <u>Stoutsville Mo</u> If not at place of death? _____ | | |
| | BIRTHPLACE OF FATHER (City or town; State or foreign country) <u>Monroe Co Mo</u> | | Former or usual residence <u>Shelbina Mo</u> | | |
| | MAIDEN NAME OF MOTHER <u>Cynthia A. Harrow</u> | | PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1910 | | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Polk Co Mo</u> | | UNDERTAKER <u>E W Herndon</u> ADDRESS <u>Pultons Mo</u> | | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo O. Painter</u> (ADDRESS) <u>Shelbina Mo</u> | | | FILED <u>10/15</u> 1910. <u>[Signature]</u> REGISTRAR | | |

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"); *Ebber pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)

