

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

PLACE OF DEATH
County Pulaski
Township Tarvern
or
Village Crocker
or
City _____ (NO. _____ St. _____ Ward)

Registration District No. 716 File No. 38889
Primary Registration District No. 5745 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lella Paine

PERSONAL AND STATISTICAL PARTICULARS

SEX Girl COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Infant
(Write the word)

DATE OF BIRTH Nov 4, 1910
(Month) (Day) (Year)

AGE _____ yrs. 11 mos. 19 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Crocker, Mo.

PARENTS
NAME OF FATHER Welburn Jones

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Calloway, Mo.

MAIDEN NAME OF MOTHER Minda Paine

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Pulaski Co, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Ray
(ADDRESS) Crocker, Mo.

Filed Nov 9, 1911, H. J. Stebbins
REGISTRAR

*MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 23, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 21, 1911, to Oct 23, 1911, that I last saw her alive on Oct 23, 1911, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

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

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

(Signed) J. E. Ray M. D.
Oct 23, 1911 (Address) Crocker, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

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

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Crocker Mo. DATE OF BURIAL Oct 24, 1911

UNDERTAKER S. Gleason ADDRESS Crocker Mo.

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*, *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.)



County Pulaski
 Township Laven
 or
 Village _____
 or
 City _____ (No. _____ St.; _____ Ward)

REGISTRARS SHALL NOT RE-
 CEIVE A FEE FOR CERTIFICATES
 UNTIL THEY ARE COMPLETED AS
 PRESCRIBED BY LAW.

Registration District No. 716 File No. _____
 Primary Registration District No. 5945 Registered No. _____

[If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number]

FULL NAME Della Paine

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
DATE OF BIRTH <u>11/11</u> (Month) <u>1910</u> (Year)		
AGE <u>11</u> yrs. <u>11</u> mos. <u>19</u> ds.		

OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
 (City or town, State or foreign country) Ind. Lemire

PARENTS
 NAME OF FATHER Walter Jones
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind. Mo.
 MAIDEN NAME OF MOTHER Margaret Paine
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Royce
 (ADDRESS) Coover

Filed Jan 6 1911 A. J. Whitman REGISTRAR
 NOV 1911

Original file, date _____, 19____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 10/23 (Month) 1911 (Year)
 I HEREBY CERTIFY, that I attended deceased from 10/21, 1911, to 10/23, 1911,
 that I last saw her alive on 10/21, 1911,
 and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:
The cause of the convulsion was not exactly known but supposed to be suggested by two Physicians to be a congestion of blood in the

Contributory enlarged blood vessels of the brain
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. C. Royce M. D.
10/23, 1911 (Address) Coover

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Coover DATE OF BURIAL 10/24 1911

UNDEXTAKER J. C. Royce ADDRESS Coover

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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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.)

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