

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

PLACE OF DEATH

County _____

Township _____

Village _____

City _____

Registration District No. 791

Primary Registration District No. 003

File No. 39780

Registered No. 10234

FULL NAME Andrew Payburg

St. 6 Ward
[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Negro SINGLE MARRIED WIDOWED OR DIVORCED Single
(If wife the word)

DATE OF DEATH Nov. 19, 1911
(Month) (Day) (Year)

DATE OF BIRTH June 10, 1894
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 18, 1911, to _____, 1911, that I last saw him alive on Nov. 18, 1911, and that death occurred, on the date stated above, at 3 a.m.

AGE 15 yrs. 5 mos. 5 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

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

234 16 (Duration) _____ yrs. _____ mos. _____ ds.
Tuberculosis, pulmonary

BIRTHPLACE (City or town, State or foreign country) Mo 3-07

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) G. H. Kashing M. D.
11/21, 1911 (Address) 100 So Jefferson Ave

NAME OF FATHER Frank Payburg

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

MAIDEN NAME OF MOTHER Alice Bingham

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the life
State _____ yrs. _____ mos. _____ ds.

(Informant) Alice Burdette
(ADDRESS) 202.5 Clark Ave.

Where was disease contracted If not at place of death?
Former or usual residence _____

Filed NOV 21 1911 Marbottarkloff
REGISTRAR

PLACE OF BURIAL OR REMOVAL Pestis, Mo DATE OF BURIAL 11/22 1911
UNDERTAKER A. Bresser ADDRESS 2330 Chestnut

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.

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, peritonaeum*, 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.)



PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City Sofaux (NO. _____ St. _____ Ward _____)

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

MISSISSIPPI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 10734

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

FULL NAME Andrew Rayburn

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)DATE OF BIRTH 6/10, 1894
(Month) (Day) (Year)AGE 15 yrs. 3 mos. 3 ds. IF LESS than 1 day, ___ hrs. or ___ min. ___OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Shoe FactoryBIRTHPLACE
(City or town, State or foreign country) MoPARENTS
NAME OF FATHER Frank Rayburn
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
MAIDEN NAME OF MOTHER Alley Binglew
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alie Burdette(ADDRESS) 2075 ClarkFiled Jun. 18, 1921 A. G. Snodgrass REGISTRAR

REGISTRAR

Original file, date NOV 2 1911

MEDICAL CERTIFICATE OF DEATH.

DATE OF DEATH 11-19, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from _____, 1911, to 11-18, 1911, that I last saw h _____ alive on 11-18, 1911, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - PulmonaryContributory
(SECONDARY) _____

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

(Signed) Dr. R. H. R. R. R. M. D.1421, 1911 (Address) 10 N. Jefferson

*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 West MemphisDATE OF BURIAL 11-22, 1911UNDERTAKER MusickADDRESS 232 Chestnut

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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