

PLACE OF DEATH

County CallawayTownship Augusta

Village _____

City _____ (NO. _____)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 106File No. 19659Primary Registration District No. 5755

Registered No. _____

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married
WIDOWED
OR DIVORCED
(Write the word)DATE OF BIRTH January 4, 1854
(Month) (Day) (Year)AGE 57 yrs. 5 mos. 19 ds. If LESS than
1 day, ___ hrs. or ___ min.?OCCUPATION (a) Trade, profession, or particular kind of work Farmer and Stockman(b) General nature of industry, business, or establishment in which employed (or employer) Buying and Shipping StockBIRTHPLACE (City or town, State or foreign country) Fauquier Co., VaNAME OF FATHER John S. Payne Sr.BIRTHPLACE OF FATHER (City or town, State or foreign country) VirginiaMAIDEN NAME OF MOTHER Ann Virginia WinesBIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) J. S. Payne
(ADDRESS) Steedman, Mo.Filed 6/23 1918 A. J. Bridges
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 23, 1918
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from June 3, 1918, to June 23, 1918, that I last saw him alive on June 28, 1918, and that death occurred, on the date stated above, at about 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Chloroform anesthesia
causing heart failure(Duration) ___ yrs. ___ mos. ___ ds.
Contributory anoxia from faulty
anesthesia & pneumonia
(Duration) ___ yrs. ___ mos. ___ ds.(Signed) W. O. Payne M. D.
W. O. Payne (Address) R. F. Fuller

*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 _____ DATE OF BURIAL _____ 1918

UNDERTAKER _____ ADDRESS _____

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*, *Compositor*, *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*, *Sarcoma*, 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

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Callaway
Township Quynassee
or
Village
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 106 File No. 19659
Primary Registration District No. 5755 Registered No. _____

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

FULL NAME Elias Thomas Payne

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Jan. 4, 1854
(Month) (Day) (Year)
AGE 57 yrs. 5 mos. 19 ds. If LESS than 1 day, ___ hrs. or ___ min.

DATE OF DEATH June 23, 1911
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred, on the date stated above, at about 10:30 a.m.

OCCUPATION (a) Trade, profession, or particular kind of work Farmer + stockman
(b) General nature of industry, business, or establishment in which employed (or employer) Buying + shipping of many feet of land
BIRTHPLACE (City or town, State or foreign country) Fauquier Co. Va.

The CAUSE OF DEATH* was as follows:
The operation was taken for Hemorrhoids
for many feet of land
(Duration) _____ yrs. _____ mos. _____ ds.

PARENTS NAME OF FATHER John S. Payne Sr.
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Abigail Virginia Wynne
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) G. S. Call M. D. (Address) P. O. Fulton

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Payne
(ADDRESS) Steedman 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 _____

Filed June 28 1911 A. D. Bridg REGISTRAR

PLACE OF BURIAL OR REMOVAL Steedman Mo. DATE OF BURIAL June 26 1911
UNDERTAKER None ADDRESS _____

N. B. GAUSKELT, D. R. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state R. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

TEMPORARILY

Revised United States Standard Certificate of Death

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

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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.)