

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

**1 PLACE OF DEATH**

County Sullivan  
Township Polk  
or  
Village  
or  
City Milan (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 852 File No. 24220  
Primary Registration District No. 6120 Registered No. 19

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

**2 FULL NAME** Taleb Payne

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <u>Male</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 SINGLE MARRIED WIDOWED OR DIVORCED</b> <u>Married</u> (Write the word)
<b>6 DATE OF BIRTH</b> <u>August 16, 1844</u> (Month) (Day) (Year)		
<b>7 AGE</b> <u>72 10 9</u> yrs. mos. ds.		<b>IF LESS than 1 day, hrs. or min.?</b>
<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work <u>Banker</u> (b) General nature of industry business, or establishment in which employed (or employer)		
<b>9 BIRTHPLACE</b> (City or town, State or foreign country) <u>Monroe Co. Ky.</u>		
<b>PARENTS</b>	<b>10 NAME OF FATHER</b> <u>Reuben Payne</u>	
	<b>11 BIRTHPLACE OF FATHER</b> (City or town, State or foreign country) <u>Tennessee</u>	
	<b>12 MAIDEN NAME OF MOTHER</b> <u>Sarah Norman</u>	
	<b>13 BIRTHPLACE OF MOTHER</b> (City or town, State or foreign country) <u>North Carolina</u>	

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**  
June 24, 1917  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY**, that I attended deceased from June 13, 1917, to June 20, 1917, that I last saw him alive on June 20, 1917, and that death occurred, on the date stated above, at 3:15 P.M.

**The CAUSE OF DEATH\*** was as follows:  
Myocarditis  
Nephritis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**CONTRIBUTORY (Secondary)** Nephritis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. M. Williams D.  
(Address) Milan Mo.

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

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) Nova J. Payne  
(Address) Milan Missouri

**18 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 \_\_\_\_\_

**15**  
Filed 6-28, 1917, Storte  
Registrar

**19 PLACE OF BURIAL OR REMOVAL** Oakwood Cem Milan Mo **DATE OF BURIAL** June 28, 1917  
**20 UNDERTAKER** O. Johnson **ADDRESS** Milan 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) *Colton 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 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.)

1 PLACE OF DEATH

County Sullivan  
Township Polk  
Village  
City

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

Registration District No. 852 File No.  
Primary Registration District No. 6120 Registered No. 19  
St. Ward)

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

2 FULL NAME

Calah Payne

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED M  
(Write the word)

6 DATE OF BIRTH  
(Month) (Day) 1 (Year)

7 AGE  
If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE  
(City or town, State or foreign country)

10 NAME OF FATHER  
11 BIRTHPLACE OF FATHER  
(City or town, State or foreign country)  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER  
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)  
(Address)

15  
Filed aug 6 1917 Porter  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
June 24 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1917 to 1917, that I last saw him at home, and that death occurred, on the date stated above, at home.  
The CAUSE OF DEATH\* was as follows:  
Acute Myocarditis

CONTRIBUTORY (Secondary)  
Nephritis  
(Duration) yrs. mos. ds.

(Signed) W. M. W. M. D.  
Milan  
1917 (Address)

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

18 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

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Satisfactory Information Supplied.  
Satisfactory Information Supplied.  
Satisfactory Information Supplied.  
Satisfactory Information Supplied.

Original file, date July 28, 1917

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]

02217

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