

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

9949

PLACE OF DEATH
County Newton Registration District No. 610
Township Newton or Village _____ Primary Registration District No. 608 File No. _____
City _____ (NO. _____) St. _____ Ward _____ Registered No. 8

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

FULL NAME Lola May Payne

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) _____

DATE OF BIRTH Sept 5th, 1918
(Month) (Day) (Year)

AGE 5 yrs. 12 mos. 12 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Newton Co Mo

PARENTS

NAME OF FATHER Charley Payne

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

MAIDEN NAME OF MOTHER Armstrong

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bertha E Ratliff
(ADDRESS) Newtonia Mo

Filed Mar 18th 1918 L. H. Casswell
April 20 1918 J. B. Slavovich REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 17, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 11th 1918, to Mar 17, 1918, that I last saw her alive on Mar 17th, 1918, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH was as follows:
Mastoidal Abscess

7 days (Duration) yrs. ___ mos. ___ ds.

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

(Signed) P. L. Freedland M. D.
Mar 18 1918 (Address) Fairview

*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 Birch Grove DATE OF BURIAL Mar 18 1918

UNDERTAKER White & Payne ADDRESS Fairview Mo

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 (NO. _____ St. _____ Ward _____)

**MISSOURI STATE BOARD OF HEALTH
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[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION	(a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____	
BIRTHPLACE	(City or town, State or foreign country) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (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 _____ m. The CAUSE OF DEATH* was as follows:

PARENTS

NAME OF FATHER _____ (City or town, State or foreign country) _____

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

MAIDEN NAME OF MOTHER _____ (City or town, State or foreign country) _____

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

Contributory
(secondary)

(Signed) _____ (Address) _____ 191____ M. D. _____

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

*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. State _____ In the _____ State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death? _____
 Former or _____
 (Qual residence)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____ (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

Filed _____, 191____ REGISTRAR _____

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

1 PLACE OF DEATH
Newton
County *Newton*
Township
or
Village
or
City

Registration District No. *610* File No.
Primary Registration District No. *5811* Registered No. *8*
City (NO. St. Ward)

2 FULL NAME *Lola May Payne*

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *Mar 17 8*
(Month) (Day) (Year)

6 DATE OF BIRTH (Month) *Sep 29* (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Mar 13 1918* to *Mar 17 1918*
that I last saw him *Mar 17 1918*
and that death occurred, on the date stated *Mar 17 1918* at *1 A.M.*

7 AGE *5* mos. *20* ds. If LESS than 1 day, ... hrs. or ... min.?

18 CAUSE OF DEATH* was as follows:
Mastoid abscess
Mastoid abscess
4 days
CONTRIBUTORY (Secondary)

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

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

10 NAME OF FATHER *C. H. Payne*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Sweden*

12 MAIDEN NAME OF MOTHER *Lottie Anderson*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Sweden*

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *4 days*
(Signed) *P. L. Brockmeyer* M. D.
(Address) *191*

*State the Disease Causing Death, or, in death 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) (Address) *C. H. Payne*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death *4* mos. *20* ds. In the State *4* yrs. *0* mos. *0* ds.
Where was disease contracted if not at place of death? *Information supplied*
Former or usual residence

15 Filed *J. B. Hancock* 1918 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL *1918*

20 UNDERTAKER ADDRESS

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.)