

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

V38416

PLACE OF DEATH

Stone  
Lincoln

Registration District No. 1000

File No. 99

Primary Registration District No. 6259

Registered No. 99

(Not)

St. Ward

NAME

Francis  
Francis Painter

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

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White  
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

BIRTH 12 10 1919  
(Month) (Day) (Year)

If LESS than 1 day... hrs. or... min.?

6 OCCUPATION, PROFESSION, OR KIND OF WORK  
7 NATURE OF INDUSTRY OR ESTABLISHMENT IN WHICH EMPLOYED (or employer)

8 PLACE OF BIRTH (of town, State or foreign country) Stone Co MO

9 NAME OF FATHER (of town, State or foreign country) Virgel Painter

10 NAME OF MOTHER Maggie Young

11 PLACE OF BIRTH (of town, State or foreign country) MO

12 I AM TRUE TO THE BEST OF MY KNOWLEDGE

13 SIGNATURE OF REGISTRAR Virgel Painter  
14 ADDRESS Crane MO R2

15 DATE OF REGISTRATION 12 1919  
16 REGISTRAR Phiz H. H. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 11 1919  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 12-8 1919 to 12-11 1919  
that I last saw him alive on 12-8 1919  
and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
108

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY

(Signed) J. C. Duggitt M. D.  
12-12 1919 (Address) Crane Mo

\*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

Delaware care MO

DATE OF BURIAL

12-12 1919

20 UNDERTAKER

Will Russell

ADDRESS

Crane R2

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. S. No. 2. A

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

## 1 PLACE OF DEATH

County .....

Township..... Registration District No. .... File No. ....

Village ..... or ..... Primary Registration District No. .... Registered No. ....

City..... (NO. ....) St. .... Ward) .....

(If de  
hospi  
give it  
of site

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

## 2 FULL NAME

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	6 DATE OF BIRTH ..... 191..... (Month) (Day) (Year)
7 AGE	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..... 191.....

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH .....

(Month) (Day)

17 I HEREBY CERTIFY, that I attended de..... 191..... to  
that I last saw h..... alive on  
and that death occurred, on the date stated above, at  
The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) .....

(Signed) .....

(Duration)..... yrs..... mo.....

(Duration)..... yrs..... mo.....

(Address) .....

\*State the Disease Causing Death, or, in deaths from Violent  
(1) Means of injury; and (2) whether Accidental, Suicidal o  
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, or Recent Residents)  
At place of death..... yrs..... mos..... ds. In the State..... yrs.....  
Where was disease contracted if not at place of death?.....  
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BUR

ADDRESS

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

**1. PLACE OF DEATH**

County Stone  
Township Lincoln  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 1044  
Primary Registration District No. 6259

File No. \_\_\_\_\_  
Registered No. 9  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Francis Painter

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(Use the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

14. INFORMANT \_\_\_\_\_  
(Address)

15. FILED \_\_\_\_\_, 19\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-11-1919

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw \_\_\_\_\_, alive on \_\_\_\_\_, 18\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_, Mo.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Lobar pneumonia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) J. C. R. Foggett, M. D.  
, 19\_\_\_\_ (Address) Case

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. URDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

No. 25. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAWS.

SUPPLEMENTARY

# 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

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"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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which gives any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.