

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

36713

1. PLACE OF DEATH

County Hickory Registration District No. 363 File No. _____
 Township Montgomery Primary Registration District No. 6308 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Della Payne

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb 20nd 1900</u>		
7. AGE <u>20</u>	YEARS <u>11</u>	MONTHS <u>22</u>
	DAYS <u>22</u>	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Girl
 (b) General nature of industry, business, or establishment in which employed (or employer) at home
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Hickory Co Mo
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>P. K. Payne</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>K. Y.</u>
	12. MAIDEN NAME OF MOTHER <u>Dora Kirkman</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT P. K. Payne
 (Address) Wheatland Mo

15. FILED Jan 8 1921 M. L. Brent
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 31st 1920
 17. I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1920, to Dec 31st, 1920, that I last saw her alive on Oct 8th, 1920, and that death occurred, on the date stated above, at 11 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
 (duration) yrs. mos. ds. 4
 CONTRIBUTORY (SECONDARY) Debility following typhoid fever
 (duration) yrs. mos. ds. 3

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? At place of death
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? none
 (Signed) J. H. Murray, M. D.
Dec 31st 1920 (Address) Quincy Mo.

*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 <u>Mt. Zion Cemetery</u>	DATE OF BURIAL <u>Jan 1st 1921</u>
20. UNDERTAKER <u>H. B. Amrine</u>	ADDRESS <u>Quincy Mo</u>

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*, *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 childbirth 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 give 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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Hickory
Township Montgomery
or
Village
or
City

Registration District No. 363 File No. 3-6-713-a
Primary Registration District No. 5378 Registered No.

(NO. St. Ward)

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

2 FULL NAME Miss Dellie ~~Payne~~ Payne

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE Single
MARRIED ~~WIDOWED~~
OR DIVORCED
(If write the word)

6 DATE OF BIRTH Feb 2 1900
(Month) (Day) (Year)

7 AGE 20 yrs. 11 mos. 22 ds. If LESS than 1 day.....hrs. or.....min.?

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

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

PARENTS
10 NAME OF FATHER P. K. Payne
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) KY
12 MAIDEN NAME OF MOTHER Dora Kiskanan
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. K. Payne
(Address) Wheatland Mo

15 Filed Feb 8th 1921 M. L. Brent
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 31st 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 4th 1920 to Dec 31st 1920, that I last saw her alive on Oct 8th 1920, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
99
(Duration) 7 yrs. 5 mos. 5 ds.

CONTRIBUTORY Schistosomiasis following
(Secondary) typhoid fever
(Duration) 7 yrs. 5 mos. 5 ds.
(Signed) J. M. Murray M. D.
Dec 31st 1920 (Address) Quincy 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 7 yrs. 5 mos. 5 ds. In the State 7 yrs. 5 mos. 5 ds.
Where was disease contracted if not at place of death? at place of death
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Zion Cemetery DATE OF BURIAL Jan 1st 1921

20 UNDERTAKER H. B. Amrine ADDRESS Quincy Mo

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