

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.

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

PLACE OF DEATH

County Pettis
Township Elk Fork
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 164
Primary Registration District No. 5883

File No. 23566
Registered No. 59

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

FULL NAME

Eliza Payton

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>Colored</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>April 3, 1898</u> (Month) (Day) (Year)		
AGE <u>16 yrs. 3 mos. 1 ds.</u>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House maid</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Pettis Co. 147 B</u>		
PARENTS	NAME OF FATHER <u>George Payton 150A</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>La.</u>	
	MAIDEN NAME OF MOTHER <u>Emaline Rucker</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Pettis Co. 8</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
June 4, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 3, 1914, to X, 191X, that I last saw her alive on June 3, 1914, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
From what her mother said it was post partum hemorrhage following 1 hour after child birth.
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) H. E. Walker M. D.
June 6, 1914 (Address) La Monte 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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo + Payton
(ADDRESS) Adelia Mo. Route 3.

PLACE OF BURIAL OR REMOVAL <u>V</u>	DATE OF BURIAL 191 <u> </u>
UNDERTAKER	ADDRESS

Filed July 10, 1914 W. C. Crobaugh
REGISTRAR

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, 8 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.)

PLACE OF DEATH

County

Township

or

Village

or

City

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

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

Registration District No.

Primary Registration District No.

File No.

Registered No.

FULL NAME

Eliza Payton

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

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR (OR) RACE B. SINGLE MARRIED WIDOWED OR DIVORCED Single (If file the word)

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

AGE If LESS than 1 day, ___ hrs. or ___ min. 2 or ___ yrs. ___ mos. ___ ds.

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)

PARENTS NAME OF FATHER BIRTHPLACE OF FATHER (City or town, State or foreign country) MAIDEN NAME OF MOTHER BIRTHPLACE OF MOTHER (City or town, State or foreign country)

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 4, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 191___ to 191___, that I last saw h___ alive, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows: Post partum hemorrhage 1 hr. after child birth

Contributory (SECONDARY) (Duration) yrs. ___ mos. ___ ds. (Signed) Dr. E. Wulfsberg M. D. 626 1914 (Address) La Monte, 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

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL ADDRESS Undertaker Robbough

Filed June 10, 1914, O. O. Laughlin REGISTRAR

Satisfactory Information supplied

Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

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

27560

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