

APR 30 1930

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

Do not use this space.

9331

1. PLACE OF DEATH
County Lawrence Registration District No. 470
Township _____ Primary Registration District No. 4283
City Mt. Vernon (No. _____) St. _____ Ward _____

File No. _____
Registered No. 18

2. FULL NAME Joseph M. Painter
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Virgie Painter
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 9 - 1861
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 9 14
8. OCCUPATION OF DECEASED Physician
(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) Bloomfield Iowa

10. NAME OF FATHER Joseph Painter
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) not known
12. MAIDEN NAME OF MOTHER Polly Russell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ind

14. INFORMANT Virgie Painter
(Address) Mt. Vernon Mo.

15. FILED April 11, 1930 W. J. Tucker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 12, 1930
17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930 to March 12, 1930
that I last saw him alive on March 10, 1930 and that death occurred, on the date stated above, at 6 P.M. About
THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suicide by poison using the drug Gelsemium
163X
011
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Melancholia
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? a letter
(Signed) H. B. ... Dep. Coroner, D.
W. J. ... Mt. Vernon Mo.
, 19 _____ (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL I.O.O.F. cemetary Mt. V DATE OF BURIAL 3/14/ 1930

20. UNDERTAKER G.B. Orr ADDRESS Mt. Vernon Mo.

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.

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