LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

26818-a

1. PLACE OF DEATH
County: Wayne
Township: Jefferson
City: ..... (No. ..... St. ..... Ward)
Registration District No. 1020
Primary Registration District No. 6190
File No. .....
Registered No. .....

2. FULL NAME: Wilma Parlee 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.

JAN 23

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: (1)
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): X
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ✓
6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 26 1828
7. AGE: YEARS 1 | MONTHS 2 | DAYS 15 | 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): Mo
PARENTS
10. NAME OF FATHER: V.D. Payne
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: M. May Bumby
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
14. INFORMANT: V.D. Payne
(Address): Arbor Mo
15. FILED: Dec 30 19..... G W Kimmel, REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 11 1929
17. I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 11, 1929, that I last saw her alive on July 13, 1929, and that death occurred, on the date stated above, at 10 P m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dysentery
130
(duration) ..... yrs. ..... mos. 8 ds.
CONTRIBUTORY (SECONDARY): 160
(duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED: at home
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No. DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) T. J. Kirkpatrick M.D.
, 19 (Address) Johnson

*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: Hopper Cem
DATE OF BURIAL: 7-12-1929
20. UNDERTAKER: Earl Wiles
ADDRESS: Arbor 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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### CERTIFICATE OF DEATH

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., .....St. .....Ward)

**2. FULL NAME** .....

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* 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) 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(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) ..... , M. D
, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.