

REC'D MAR 9 1939

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

5641  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Blue Primary Registration District No. 1002 Registered No. 840  
 (c) City Kansas City, Mo. (d) Street No. Leeds Hospital (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME W. Z. Lue Payne  
 (a) Residence, No. 3829 Broadway St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mother Eva Watts

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3, 1911

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
28 10 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Armstrong Mo.

FATHER  
 13. NAME Berline Payne  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

MOTHER  
 15. MAIDEN NAME Eva Wright  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

17. INFORMANT (ADDRESS) K. S. T. B. Hosp. Leeds, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE 2-25, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bevitt Funeral Home 1119 1/2 St. K.C. Mo.

20. FILED 7-25 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 21, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 15, 1937 to Feb 21, 1939  
 I last saw her alive on Feb 21, 1939. Death is said to have occurred on the date stated above, at 12:45 P.M.  
 The principal cause of death and related causes of importance were as follows:  
PULMONARY TUBERCULOSIS Date of onset 1937

Other contributory causes of importance:  
23

Name of operation Sputum Date of NO  
 What test confirmed diagnosis X-RAY Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) W. D. Buchanan M. D.  
 (Address) Leeds, 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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_

*Clifford L Woods*

or by \_\_\_\_\_

Registered Apprentice No. ~~3106~~ \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

*Clifford L Woods*

Licensed Embalmer No. *3106*

P. O. Address \_\_\_\_\_

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.