

Registration District No. 200

Primary Registration District No. 0725

Registrar's No. 67

6100  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Macon Twp  
(b) City or town Hudson Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 10  
(c) City or town Columbia 2  
(If outside city or town limits, write "RURAL") 7  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel M. Payne

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife B M Payne 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased don't know 1881  
(Month) (Day) (Year)

8. AGE: Years 61 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo (City, town, or county) (State or foreign country)

10. Usual occupation House keeper

11. Industry or business \_\_\_\_\_

12. Name Peter Finie

13. Birthplace Don't know 9 (City, town, or county) (State or foreign country)

14. Maiden name Maud Calvert

15. Birthplace Don't know 4 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs W L Eckhart

(b) Address Columbia Mo

17. (a) removal (b) Date thereof July 15-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Mo

18. (a) Signature of funeral director Albert Skinner

(b) Address Macon Mo

19. (a) 8/7/42 (b) Gra B. Dunkel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1942 hour 5 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from July 1 1942 to July 15 1942  
that I last saw her alive on July 15 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocardial degeneration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 93d  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 2

23. Signature Frank J. Gaspard (M.D. or other) P.O.

Address 111 Hillside Date signed 8/16/42

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

JUN 13 1942

RECEIVED

District Health Officer No. 10

District File Number 8-42-1564

Date Filed AUG 12 1942

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, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Ullat Skinner

Licensed Embalmer No. 751

P. O. Address Macon Mo

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, fact should be so stated above.