

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37873

FILED DEC 8 1943

State File No. _____

Registration District No. 47

Primary Registration District No. 3164

Registrar's No. 369

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

1. PLACE OF DEATH:

(a) County CALLAWAY

(b) City or town RURAL FULTON TOWNSHIP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.F.D.#6
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
years, months or days) wife (Specify whether

3. (a) PRINT FULL NAME MAUDE PAYNE

3. (b) If veteran, name war NO

3. (c) Social Security No. NDNR

4. Sex FEMALE 5. Color or race White

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife SCOTT PAYNE

6. (c) Age of husband or wife if alive 61 years (Month) (Day) (Year)

7. Birth date of deceased Feb 28 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

53 8 3 hr. min.

9. Birthplace CALLAWAY CO. MO. D
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name W. H. CONNOR

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

14. Maiden name MELISSA McDONALD

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

16. (a) Informant WM PAYNE

(b) Address FULTON, MO. R.F.D.#6

17. (a) BURIAL (b) Date thereof NOV. 3, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HAMS PRAIRIE

18. (a) Signature of funeral director Glen J. Maupin

(b) Address 712 Com. St. Fulton, Mo

19. (a) NOV 3-1943 (b) Joan Moss
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County CALLAWAY

(c) City or town RURAL 014
(If outside city or town limits, write "RURAL") 0

(d) Street No. FULTON, MO. R.F.D.#6 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 1
year 1943 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan 1
5 1938 to Nov 1 1943
that I last saw her alive on Nov 1 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Diabetes Mellitus

Duration of Illness 70 yrs

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

23. Signature W. Payne (M. D. or other) 0

Address R # 5 Fulton Date signed 11/1/43

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.....

Glen Y. Mansin

Licensed Embalmer No.....

2725

P. O. Address.....

Fulton, 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.

Registration District No. 47

Primary Registration District No. 5164

Registrar's No. 369

1. PLACE OF DEATH:

(a) County Callaway
 (b) City or town Rural Fulton 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

3. (a) PRINT FULL NAME Maude Payne

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 28
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days _____
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrum of Venereal Disease
Scabies Mollusca

Due to _____

Due to _____

Other conditions (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 _____

23. Signature W. O. Payne (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

458

37873