

S. No. 2
FORM-5-43
REV. 5-17-39
W I X36671

FILED NOV 2 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Stoddard J. Payne

3. (b) If veteran, name war Yes

3. (c) Social Security No. 488-18-2140

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 24 years (Day) (Year)

7. Birth date of deceased Nov. 24 1881
(Month) (Day) (Year)

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

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hr. min.

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

10. Usual occupation Garage Manager

11. Industry or business John W. Payne

12. Name Frankfort Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Grisham
(City, town, or county) (State or foreign country)

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

16. (a) Informant James Payne

(b) Address 3737 Upton

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Oct. 27, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Wacker Skidmore
3634 Gravois Ave.

(b) Address OCT 27 1945

19. (a) J. F. Bradeau (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3737 Upton
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25 year 1945 hour 5 minute 10 P. M.

21. I hereby certify that I attended the deceased from 7-31-45 to 10-25-45
that I last saw him alive on 10-25-45 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic

Due to Hypertension

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) (2) Means of injury _____

Signature J. F. Bradeau (M. D. or other) _____
Address 2682 S. Brady Date signed 10/26/45

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.....

Robert Wheeler

Licensed Embalmer No.....

2178

P. O. Address.....

St. Louis, 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.