

FILED DEC 12 1945  
318

1003

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether  
In this community 25 yrs  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4357 A Maffitt  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Annie Payton

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race col. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife hus Charles W. Payton 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased July (Month) 23 (Day) 1890 (Year)

8. AGE: Years 55 Months 4 Days 8 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business nil

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Charles W. Payton

(b) Address 4357 a Maffitt Ave.

17. (a) Burial (b) Date thereof 12-6-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Joseph C. Wright

(b) Address 1210a Weston Ave.

19. (a) DEC 3 1945 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 1  
year 1945 hour 6 minute 21 A. M.

21. I hereby certify that I attended the deceased from  
Nov. 29, 1945, to Dec. 1, 1945,  
that I last saw her alive on Dec. 2, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral Hemorrhage Duration unk

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

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy None

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) (b) Means of injury \_\_\_\_\_  
23. Signature Char. T. Atkinson (M. D. or other)  
Address 2601 N. Wheeler Date signed 12/3

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

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**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 Char. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2834 Hamble

**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.**