.S. No. 2
DM—8-43
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 16 1945

State File No. 36508

Registration District No. 2 Primary Registration District No. 4009 Registrar's No. 8

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

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Cosby (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no home!
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ______ In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Andrew
(c) City or town Cosby (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

3. (a) PRINT FULL NAME Mary Elenor Payne
3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Chas 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased 3 (Month) 3 (Day) 1869 (Year)

8. AGE: Years 76 Months 8 Days — If less than one day ___ hr. ___ min.

9. Birthplace Helena (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Sandusky
13. Birthplace Ind. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Amanda Thacker
15. Birthplace Plattsburg (City, town, or county) (State or foreign country)

16. (a) Informant Wm Payne
(b) Address Lyman NeBR
17. (a) Union Chapel (Burial, cremation, or removal) (b) Date thereof Oct 3 45 (Month) (Day) (Year)
(c) Place: burial or cremation Union Chapel
18. (a) Signature of funeral director John Bram
(b) Address Maryville Mo
19. (a) 10-3-45 (Date received local registrar) (b) Lillian Sparks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1 year 1945 hour 3 minute 40 A.M.
21. I hereby certify that I attended the deceased from Oct. 1, 1945 to Oct. 1, 1945
that I last saw her alive on Oct. 1, 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial Degeneration Duration
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature W. E. Maxwell (M. D. or other) D.O.
Address Cosby, Mo. Date signed 10/8/45

(Licensed Embalmer's Statement on Reverse Side)

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 John G Biam

Licensed Embalmer No. 3933

P. O. Address Maysville, ms

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.