

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6687

FILED MAR 5 1952

Registrar's No. 1211

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1211	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 21 2302a Sheridan			
3. NAME OF DECEASED (Type or Print) a. (First) Martha b. (Middle) _____ c. (Last) Payne			4. DATE OF DEATH (Month) (Day) (Year) Feb. 4 1952				
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed		8. DATE OF BIRTH Apr. 1, 1882	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Shannon, Miss.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Drex Fields		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Jackson Payne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ted Payne 2302a Sheridan			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 17 days			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis				DUPLICATE			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arterio sclerosis DUE TO (c) _____				Undet.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1332X			
22. I hereby certify that I attended the deceased from 1-18, 1952 to 2-4, 1952, that I last saw the deceased alive on 2-4, 1952, and that death occurred at 8:45p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Wm F Reid M. D.				23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 2-6-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-11-52		24c. NAME OF CEMETERY OR CREMATORY Oakdale		24d. LOCATION (City, town, or county) (State) Lemay Mo.	
DATE REC'D BY LOCAL REG. FEB 7 1952		REGISTRAR'S SIGNATURE Carl Smith, M.D.		25. GENERAL DIRECTOR'S SIGNATURE E. P. Koonce		ADDRESS 1221 N. Grand	

(Licensed Embalmer's Statement on Reverse Side)

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

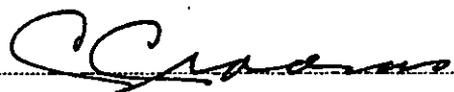
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed 

Licensed Embalmer No. 4755

P. O. Address 1221 N. Grand

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.