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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29727

State File No. \_\_\_\_\_

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6070 Registrar's No. 298

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Farmington</u> OR TOWN <u>Rural St. Francois</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Crocker</u> OR TOWN <u>0250</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ALBERT</u>	b. (Middle) <u>SIDNEY</u>	c. (Last) <u>PAYNE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 16, 1953</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>February 1879</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>6</u> Days	IF UNDER 12 HRS. Hours <u>0</u> Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber and salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>meat packers</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Crocker, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Payne</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lulu Routh</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records, State Hospital No. 4, Farmington, Mo.</u>	ADDRESS
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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 <u>Abt. 20 das.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Inanition</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Psychosis with cerebral arteriosclerosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>306X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan. 3, 1951, to August 16, 1953, that I last saw the deceased alive on August 16, 1953, and that death occurred at 3 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>John P. Brennan, M.D.</u>	(Degree or title)	23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>	23c. DATE SIGNED <u>8-18-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8-20-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington Univ. Anat. Dept.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Aug 18, 1953</u>	REGISTRAR'S SIGNATURE <u>Ester R. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Cozean Funeral Home, Farmington, Mo.</u>	ADDRESS
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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 \_\_\_\_\_

*Not embalmed when received*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

*Not  
Embalmed*

Signed *Edward W. Deussay*  
*Professor of Anatomy, Washington*  
Licensed Embalmer No. \_\_\_\_\_ *4444*

P. O. Address \_\_\_\_\_

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.