

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36741

STATE FILE NUMBER

FILED NOV 4 1957

Registration District No. 242 Primary Registration District No. 5830 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Scott</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>P. F. D. West. Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Sikeston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Canalou, Jty.</u>			Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>517 Cleveland</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie Kathleen Payne</u>			4. DATE OF DEATH <u>10-1-1957</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
5. SEX <u>F. Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1925</u>	9. AGE (In years last birthday) <u>32</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawrence</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <u>Glen, Mo.</u>	
13. FATHER'S NAME <u>Ben Payne</u>			14. MOTHER'S MAIDEN NAME <u>Cara Welty</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Cara Welty</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>No Medical Attendant, by all records</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>death was due to a car accident, in which</u> DUE TO (c) <u>the above was riding.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Two cars run together</u>			
20c. TIME OF INJURY Hour Month, Day, Year a. m. <u>Oct. 1, 57</u> p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>County Road</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>West Sup. New Madrid, Mo.</u>	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. Hedgespeth</u>			22b. ADDRESS <u>New Madrid, Missouri</u>		22c. DATE SIGNED <u>10/2/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-4-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>	
23d. LOCATION (City, town, or county) <u>Sikeston, Mo.</u>		23e. (State)			
24. FUNERAL DIRECTOR <u>Callerton Funeral Home</u>		ADDRESS <u>Sikeston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-10-57</u>	
26. REGISTRAR'S SIGNATURE <u>Kathryn L. McBain</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

300
1-56

17-

1 Sikeston, Mo. (Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED OCT 21 1957
NEW MADRID CO. HEALTH CENTER

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.....
Signature of Student Embalmer

Signed *Earl J. Smith*

Licensed Embalmer No. *76*

P. O. Address *Oron*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.