

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38816

STATE FILE NUMBER

FILED NOV 5 1957

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 194

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Marshall</u> <u>0972</u> <u>0</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>68 W. Jackson St</u>			Length of stay in lb <u>57 Yrs</u>		d. STREET ADDRESS (If outside, give location) <u>68 W. Jackson</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Parker</u> Middle <u>Alvin</u> Last <u>Payne</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26-1879</u>			
9. AGE (In years - last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Police Work-Also retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Nebraska City, Nebr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Robert A. Payne</u>				14. MOTHER'S MAIDEN NAME <u>Susan Austin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes-Spanish American</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>A.M. Payne-Slater, Mo.</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>Coronary Occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 M 11</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>12 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>P.L. Lawless M.D., Coroner Saline Co.</u>				(Degree or title) <u>3</u>		22b. ADDRESS <u>Marshall Mo.</u>		22c. DATE SIGNED <u>10-30-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/30/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park</u>		23d. LOCATION (City, town, or county) <u>Marshall Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>J. Leslie Swearing</u>			ADDRESS <u>Marshall Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-30-57</u>		26. REGISTRAR'S SIGNATURE <u>Cecil G. Reed</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare Public Service
S. 300
V. 1-56
Director, 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.
23

(Licensed Embalmer's Statement on Reverse Side)

NOV 5
MAY 28 1958

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 *J. Leslie Swenson*

Licensed Embalmer No. 32

P. O. Address *Marabel*

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.