

FILED DEC 3 - 1957

## STANDARD CERTIFICATE OF DEATH

39738

STATE FILE NUMBER

Health,  
& Welfare  
Public  
ServiceRegistration District No. 93 Primary Registration District No. 4153 Registrar's No. 57-85

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Greenfield</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>Memorial Hosp.</u>		Length of stay in lb <u>7 days</u>	d. STREET ADDRESS (If outside, give location) <u>419 Maple St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Donald</u> Last <u>Payne</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>M.</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>Aug. 16, 1868</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney-at-law</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTH PLACE (City and state or country) <u>Dade County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Payne</u>			14. MOTHER'S MAIDEN NAME <u>Amanda Scott</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Spanish-American</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Nell Payne; Greenfield, 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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	- 332X
	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>Influenza.</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 _____ Month _____ Day _____ Year _____ 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 <u>11-12-57</u> to <u>Nov. 24, 1957</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>11-23-57</u> Death occurred at <u>1:45</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Lee A. Mc Neely, M.D.</u>	22b. ADDRESS <u>Greenfield, Mo.</u>	22c. DATE SIGNED <u>11-25-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-26-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo.</u>
24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-26-57</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S. 300  
v. 1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. 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.

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DEC 11 1957  
DEC 5 1957

APR 21 1960

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. C. Canada*

Licensed Embalmer No. *419*

P. O. Address *Greenfield*

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.