

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39871
STATE FILE NUMBER

FILED NOV 18 1957

Registration District No. 111 Primary Registration District No. 5427 Registrar's No. 21

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE MO. b. COUNTY FRANKLIN)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ROBERTSVILLE, R.R.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN ROBERTSVILLE 03
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS R.R. 2
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First STELLA	Middle EMMA	Last PAYTON	Month 11	Day 1	Year 1957	

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 27, 1884	9. AGE (In years birthday) 73	10. F UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
-------------------------	----------------------------------	---	--	---	------------------------------	------------------------------	-------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	---

13a. FATHER'S NAME SAMUEL MC QUARY	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE HENRY PAYTON
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address ALBERT W. STAUB 415 LEE, KIRKWOOD
--	--	--

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><i>Influenza</i></u>		INTERVAL BETWEEN ONSET AND DEATH <u><i>Unknown</i></u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u><i>(unattended by physician)</i></u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 481X		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 <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 alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>T. J. Stumbeck M.D.</i> (Degree or title)	22b. ADDRESS <i>Union Mo</i>	22c. DATE SIGNED <i>11/5/57</i>
--	---------------------------------	------------------------------------

23a. BURIAL, CREMATION, REBURYAL (Specify) BURIAL	23b. DATE Nov. 5, 1957	23c. NAME OF CEMETERY OR CREMATORY ALLENTON CEMETERY	23d. LOCATION (City, town, or county) (State) ALLENTON MO.
---	----------------------------------	--	--

24. FUNERAL DIRECTOR <i>E. G. Altman</i>	ADDRESS UNION, MO.	25. DATE RECD. BY LOCAL REG. 11-19-57	26. REGISTRAR'S SIGNATURE <i>Thomas L. Durdon</i>
---	------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

74
0

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 *Ralph Ollman*
Licensed Embalmer No. *4808*
P. O. Address *Union, N.C.*

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.