

FILED MAR 3 - 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005767  
STATE FILE NUMBER  
702

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2244 EAST 69 <sup>th</sup> TERR.		d. STREET ADDRESS (If outside, give location) 510 WEST 39 <sup>th</sup> TERR.	
3. NAME OF DECEASED (Type or print) EFFIE		4. DATE OF DEATH FEB. 9, 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 10, 1862
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 20 YRS. NURSE		10b. KIND OF BUSINESS OR INDUSTRY PRACTICAL	11. BIRTHPLACE (City and state or country) MIAMI, MISSOURI
13a. FATHER'S NAME E. D. EMERSON		13b. MOTHER'S MAIDEN NAME ANNIE WHITE	14. NAME OF HUSBAND OR WIFE GEORGE W. PAYNE
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 MRS. JAMES R. WARREN - 2244 EAST 69 <sup>th</sup> TERR.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. - Probable Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension - Arteriosclerotic Heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 15 years 33 1/2
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.) Fall - it appears after the C.V.A.	
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 checked="" type="checkbox"/>	
21. I attended the deceased from 2-4-1944 to 2-9-58 and last saw her alive on 2-9-58 Death occurred at 6:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
22a. SIGNATURE Frank Bleich M.D.		22b. ADDRESS 1530 Prof. Bldg. Univ. of Mo.	
22c. DATE SIGNED 2-10-58		22d. PLACE OF SIGNATURE _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB-12-1958	
23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY		23d. LOCATION (City, town, or County) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS - KANSAS CITY, MO		25. DATE RECD. BY LOCAL REG. 2-10-58	
26. REGISTRAR'S SIGNATURE neva Marshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Frank B. Leitz



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 *Vern Lawler* .....

Licensed Embalmer No. *4915* .....

P. O. Address *N.C. No* .....

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.