

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014554

FILED VS MAY 5 1960

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 40

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Clay</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> Length of stay in 1b <u>1 day</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>208 Westview Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>M.</u> Last <u>Payne</u>			4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1960</u>				
5. SEX <u>female</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>5-17-1901</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ashley, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>J. V. Crowe</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Clark</u>		14. NAME OF HUSBAND OR WIFE <u>Marion Payne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Glen Carroll, Excelsior Springs, 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 hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Pre senile arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a) <u>Previous cerebral hemorrhage - 1954</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>		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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE		
21. I attended the deceased from <u>July '54</u> to <u>April 22 '60</u> and last saw her <u>live</u> on <u>April 21, '60</u> Death occurred at <u>12:40 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>George E. Anderson M.D.</u>			22b. ADDRESS <u>Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>4-23-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 23, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo</u>		
24. FUNERAL HOME, ADDRESS <u>Excelsior Springs, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>4/30/60</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or By _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Chelton Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.