

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019882

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1324

STATE FILE NUMBER

FILED MAY 22 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. John's</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>St. Charles</u>
Length of stay in 1b <u>WKS.</u>		c. CITY OR TOWN <u>Portage De Sioux</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rugh Manor Rest Home</u>		d. STREET ADDRESS <u>R. R. #1</u>	(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Stella</u>	Middle <u>Irene</u>	Last <u>Payne</u>	4. DATE OF DEATH	Month <u>May</u>	Day <u>9</u>	Year <u>1961</u>
-------------------------------------	------------------------	------------------------	----------------------	------------------	---------------------	-----------------	---------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1897</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Charles County, U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY
--	-----------------------------------	---	-----------------------------

13a. FATHER'S NAME <u>Alfred Payne</u>	13b. MOTHER'S MAIDEN NAME <u>Cordelia Goddard</u>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

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>Benjamin Payne</u>	Address <u>Portage De Sioux</u>
---	--	--	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-sclerotic cardio vascular Disease</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) <u>Secondary Hypertension</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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"/> <u>None</u>	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.	Month, Day, Year
---	------------------

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 3-29-61 to 5-9-61 and last saw her alive on 5-9-61
Death occurred at 6:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Allen McNearney M.D.</u>	22b. ADDRESS <u>4308 E. Peter</u>	22c. DATE SIGNED <u>5-11-61</u>
---	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>5/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles Missouri</u>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Arthur C. Baue</u>	ADDRESS <u>St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-11-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
---	------------------------------------	--	---

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1961 JUN 7 SA

MAY 1 1962

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 David C. Bane

Licensed Embalmer No. 5060
P. O. Address S. J. Charles

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.