

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040884

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Primary Registration District No. 5856 Registrar's No. 53

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. 142 Primary Registration District No. 5856 Registrar's No. 53

FILED NOV 28 1961

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain View</u>		Length of stay in lb <u>15 Days</u>	c. CITY OR TOWN <u>Willow Springs,</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>St. Francis Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Gen. Delivery</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>W.</u> Last <u>PAYNE</u>			4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>9/10/02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railway</u>	9. AGE (last birthday) <u>69</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u> Hours <u></u> Min. <u></u> IF UNDER 24 HR
11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Payne</u>		13b. MOTHER'S MAIDEN NAME <u>Tennessee Coble</u>	14. NAME OF HUSBAND OR WIFE <u>Effie Payne</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Effie Payne, Willow Springs, Mo.</u> Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause (ast.) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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			INTERVAL BETWEEN ONSET AND DEATH
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. 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 <u>2/1/60</u> to <u>11/14/61</u> and last saw her/him alive on <u>11/14/61</u> Death occurred at <u>7 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Amos Coffee M.D.</u> (Degree or title) <u>Amos Coffee, M.D.</u>		22b. ADDRESS <u>Willow Springs, Mo.</u>	22c. DATE SIGNED <u>11/15/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/17/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Willow Springs, Mo.</u>
24. FUNERAL DIRECTOR <u>Burns Funeral Home, Willow Spgs., Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-21-61</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>

NOV 29 1961

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

Thomas R. Burns

Signed Thomas R. Burns

Licensed Embalmer No. 4214

P. O. Address Willow Springs,

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.