WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

PLACE OF DEATH

County: Pettis

Township: ____ or Village: ____ or City: Sedalia (NO. ____, ____ St.; ____ Ward)

Registration District No. 668 — File No. 34466

Primary Registration District No. 9032 — Registered No. 280

[If death occurred in a hospital or Institution, give its NAME instead of street and number]

FULL NAME: Boyd Junior Payne

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Male

COLOR OR RACE: White

SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word): S

DATE OF BIRTH: November (Month) 7 (Day), 1915 (Year)

AGE: ____ yrs. ____ mos. 14 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): L

BIRTHPLACE (City or town, State or foreign country): Sedalia

PARENTS
NAME OF FATHER: Andrew Boyd Payne
BIRTHPLACE OF FATHER (City or town, State or foreign country): Biddleton Tenn.
MAIDEN NAME OF MOTHER: Ada Bell Allegra
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Gharden Co. State Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Boyd Payne

(ADDRESS) 504 E. 3rd St. Sedalia Mo

Filed Nov 21, 1915. H. B. Long, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: November (Month) 20 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 7, 1915, to Nov. 20, 1915, that I last saw him alive on Nov. 19, 1915, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows: Hemorrhage for Ruptured Hematocele

64

160B
161D

(Duration) ____ yrs. ____ mos. 14 ds.

Contributory (SECONDARY) Instrumental Traumatism at Birth (Duration) ____ yrs. ____ mos. 14 ds.

(Signed) E. A. Staat M. D.

Nov. 21, 1915 (Address) 104 W. Main, Sedalia Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Fayette Mo — DATE OF BURIAL: Nov. 22, 1915

UNDERTAKER: McLaughlin Bros. — ADDRESS: Sedalia

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** .....

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

..... , 1..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... , 191..... REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ..... , 191..... to ..... , 191..... , that I last saw h..... alive on ..... , 191..... , and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... , 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| | ..... , 191..... |
| **UNDERTAKER** | **ADDRESS** |
| | |