

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

Do not use this space.

42867

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis

Registration District No. 791
Private Registration District No. 11003
(No. Wrightman Hospital)

File No. _____
Registered No. 12135
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 4036 Maffis Pl St. 11 Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 5, 1870

7. AGE YEARS 58 MONTHS 7 DAYS 6 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Water Dept
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Massachusetts

PARENTS

10. NAME OF FATHER John A. Payne

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Massachusetts

12. MAIDEN NAME OF MOTHER Sarah Jennings

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Frank J. Payne (Address) 4036 Maffis Pl

15. FILED DEC 13 1928 Wm. C. Shankley REGISTAR

3. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 11, 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial infarction due to cerebral hemorrhage
no labor or cramps #703 Hemiplegia
due to cerebral hemorrhage (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) apparently with paralysis (duration) 2 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF BOY AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHICH TEST CONFIRMED DIAGNOSIS? Chemical & autopsying
(Signed) R. B. Cappel, M. D.
, 19____ (Address) 3239 Franklin

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL 12/14/28

20. UNDERTAKER Mullen and Co. 5165 Belmont ADDRESS _____

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.

