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

Do not use this space.

791
1003

3398 ~~3194~~

File No. 3398
Registered No. 896

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. 4291 Farlin Ave St. ..... Ward)

2. FULL NAME Elizabeth Payne

(a) Residence. No. ..... St., 10 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ ~~HUSBAND~~ OF (OR) WIFE OF Frank Payne

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 5, 1871

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	1	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Spring Bluff
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Winfield Scott
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Pennsylvania
12. MAIDEN NAME OF MOTHER Paulina Inman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) England

14. INFORMANT Mrs Wm. Briegler
(Address) 4291 Farlin Ave

15. JAN 28 19 30 Filed ..... Rex C. Harlow Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Jan 27, 1930, that I last saw her alive on Jan 25, 19.... and that death occurred, on the date stated above, at 7.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Esophagus & Stomach & intestines
No P.M.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical, Clinical Exp.
(Signed) W. Walter M. D.
Jan 29, 1930 (Address) 5201 Va

*State the DISEASE CAUSING DEATH, or if 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	DATE OF BURIAL
Mt Hope Cemetery	1/29 1930
20. UNDERTAKER	**ADDRESS**
C. Hoffmeister U.S.L.Co.	7814 S. Broadway

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

2 2 1 2 3 5

5201 E Virginia
5032 S. Grand
Ri 0523