

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

Do not use this space.

18131

1. PLACE OF DEATH *Jackson*
 County *Kan* Registration District No. **389**
 Township *Kansas City* (No. *1002*) Primary Registration District No. **1002**
 City *Kansas City* (No. *1002*) Registered No. *2272*
 (No. *1002*) (St. *1002* Ward)

2. FULL NAME *Blairnce Payne*
 (a) Residence. No. *575 Harrison St.* Ward. *1*
 (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 *Om*
 4. COLOR OR RACE *B*
 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) *unknown*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Laborer 237*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Isaac Payne*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*
 12. MAIDEN NAME OF MOTHER *Rhoda Boswell*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

14. INFORMANT *May Clark*
 (Address) *St. Joe, Mo.*

15. FILED *May 19 31* *M. M. Cronin*
 REGISTRAR *ans*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-17-31*
 17. I HEREBY CERTIFY, That I attended deceased from *17-1931*
, 19....., to, 19.....
 that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at, m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental - automobile
fracture of (duration) yrs. mos. ds.
 CONTRIBUTORY *Pediatrician - K. G. Mo*
 (SECONDARY) (duration) yrs. mos. ds.

19. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? DATE OF.....
 WAS THERE AN AUTOPSY? *yes*
 WHAT TEST CONFIRMED DIAGNOSIS? *autopsy*
 (Signed) *Dr. Luntz* M. D.
 (Address) *Deputy Coroner*

*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 *St. Joe Mo* DATE OF BURIAL *5-19 1931*

20. UNDERTAKER *W. H. Guntter* ADDRESS *St. Joe 1606 E. 18*

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.

