

MISSOURI STATE BOARD OF HEALTH

Do not use this space.

SEP 7 3 1934

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31265

1. PLACE OF DEATH *4055 Coake*

County.....

Registration District No. *791*

Township.....

Primary Registration District No. *1009*

City *St. Louis, Mo.* (No.)

File No.

Registered No. *8567*

St. Ward)

2. FULL NAME *Clasac Payne*

(a) Residence, No. *4055 Coake, ave.* St. *11* Ward.

(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 <i>male</i>	4. COLOR OR RACE <i>colored</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>7001 8/20/1877</i>		
7. AGE YEARS <i>57</i>	MONTHS <i>0</i>	DAYS <i>2</i>
If LESS than 1 day, hrs. or min.		

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Porter in</i>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>shoe store</i>
	10. Date deceased last worked at this occupation (month and year).....
	11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mo.*

MOTHER FATHER 13. NAME *Allen Payne*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mo.*

15. MAIDEN NAME *Amanda Gashway*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mo.*

17. INFORMANT *Mrs. Charles Payne*
(ADDRESS) *4055 Coake, ave.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Greenwood* DATE *Aug. 24* 19*34*

19. UNDERTAKER *Wm. O. M. O'Connell*
(ADDRESS) *2505 Franklin Ave.*

20. FILED *AUG 24* 19*34* *J. Bredeck*
Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 21* 19*34*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 5* 19*34* to *August* 19*34*
I last saw him alive on *Aug 5* 19*34* Death is said to have occurred on the date stated above at *6:30 p.* m.
The principal cause of death and related causes of importance were as follows:

Valvular Heart Disease
131
Chronic Nephritis
6440

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify *Same*
(Signed) *Samuel Stafford* M. D.
(Address) *925 N. Jefferson*

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.

