

JAN 2 1935

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

Do not use this space.

Dr. Waterman
42667
File No. 613
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County *Franklin* Registration District No. *318*
Township *Franklin* Primary Registration District No. *5440*
City *Franklin* (No. *Franklin*)

2. FULL NAME

(a) Residence, No. *Ret # 4* St. _____ Ward _____

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Will B Payne*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 22 - 1882*

7. AGE YEARS *52* MONTHS *2* DAYS *22* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as planter, Sawyer, bookkeeper, etc. *Insurance*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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) *Franklin Mo*

13. NAME *W B Payne*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME *Marion Wade*

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

17. INFORMANT (ADDRESS) *Will B Payne*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Franklin* DATE *Dec 15* 19*34*

19. UNDERTAKER (ADDRESS) *Franklin Mo*

20. FILED *12-15* 19*34* *Franklin Mo*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12 - 14 - 1934*

22. I HEREBY CERTIFY That I attended deceased from *Dec 1* 19*34*, to *Dec 14* 19*34*

I last saw him alive on *Dec 14* 19*34*. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
mitral insufficiency
Chronic Bronchitis
Influenza 10 years ago
Date of onset *Unknown*

Other contributory causes of importance: _____

Name of operation *none* Date of _____
What test confirmed diagnosis *Examination* Was there an autopsy? *No*

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? _____
If so, specify _____

(Signed) *Newton Waterman* M. D.
Ed Artobly, Springfield, Mo (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.

