

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

37043  
 Do not use this space.

RECD NOV 24 1939

1. PLACE OF DEATH  
 (a) County St Charles Registration District No. 76  
 (b) Township Curran Primary Registration District No. 44  
 (c) City Wentzville (d) Street No. \_\_\_\_\_ St.  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 500 Mrs. Margaret Eliza Payne  
 (a) Residence, No. Wentzville Mo St.  (If nonresident, give city or town and State)  
 (Usual place of abode) (If no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widowed

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_ ✓

| 7. AGE    | YEARS     | MONTHS    | DAYS | If LESS than 1 day, .....hrs. or .....min. |
|-----------|-----------|-----------|------|--|
| <u>79</u> | <u>11</u> | <u>10</u> |      |  |

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as 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) St Charles Mo

FATHER  
 13. NAME Washington Sims  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Mo

MOTHER  
 15. MAIDEN NAME Adeline Lawson  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT (ADDRESS) Phelby Galloway, Wentzville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Hopewell DATE Oct. 6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. Keithly, Galloway Mo

20. FILED Oct. 10 - 1939 Gertrude S. Forister, Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug - 2, 1939, to Oct - 7, 1939  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 8 P m.  
 The principal cause of death and related causes of importance were as follows:  
Inter. Sclerosis  
arteriosclerosis  
hypertension  
grandiose of St. foot

Other contributory causes of importance:  
hypertension  
grandiose of St. foot

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?  
 If so, specify \_\_\_\_\_ (Signed) D. J. V. [Signature] M. D.  
 (Address) 200 Main St. St. Charles Mo

W. H. J. J. J.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed E. Keethy

Licensed Embalmer No. 8227

P. O. Address .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

37043

Do not use this space.

1. PLACE OF DEATH

(a) County St Charles Registration District No. 760 A  
(b) Township \_\_\_\_\_ Primary Registration District No. 4455 Registered No. \_\_\_\_\_  
(c) City Wentzville (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mrs Margaret Eliza Payne  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 23 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 11 10

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as 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)

FATHER  
13. NAME

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

MOTHER  
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED

12/18 39 Gertrude S. Forister  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 3 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. 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:

Date of onset

Other contributory causes of importance:

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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) W. H. Taylor, M. D.

(Address) St Charles

