

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.

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 338

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
932 No. Spring
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 932 North Spring
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME: Charles L. Payne

3. (b) If veteran, name war: none
3. (c) Social Security No. none

4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: widowed

6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Mar 7 - 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 27
If less than one day _____ hr. _____ min.

9. Birthplace: Joplin, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Retired Miner

11. Industry or business: _____

MOTHER FATHER { 12. Name: Mark Payne (a) _____ (b) _____

13. Birthplace: unknown (City, town, or county) (State or foreign country)

14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mrs. Maud Heger
(b) Address: 932 No. Spring

17. (a) Burial (b) Date thereof: 11-6-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: ground
18. (a) Signature of funeral director: George C. Eason
(b) Address: Independence, Mo.

19. (a) 11-9-39 (b) J. L. Cook
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day nov
year 1939 hour 4 minute 25 A.M.

21. I hereby certify that I attended the deceased from Apr, 1939, to Nov 4, 1939;
that I last saw him alive on Nov 3, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death: Valvular Heart disease Duration 2 yrs

Due to _____
Due to arteriosclerosis 5 yrs

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 920
Of operations:
Of autopsy:
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence: _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) _____
(e) Means of injury: _____

23. Signature: J. L. Hickerson (M. D. or other) _____
Address: Independence, Mo. Date signed: Nov 6, 39

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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