

APR 22 1940

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

10789
Do not use this space.

1. PLACE OF DEATH

(a) County Hall Registration District No. 244
 (b) Township Jeffers Primary Registration District No. 5338 Registered No.
 (c) City Jeffers (d) Street No. 0 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Anna Hess Paylor

(a) Residence, No. 1 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (wid the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 28 - 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 6 11

OCCUPATION 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) Pa.

FATHER 13. NAME ✓

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

MOTHER 15. MAIDEN NAME ✓

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

17. INFORMANT (ADDRESS) Mrs J. E. Vanner
Buffalo Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Plain DATE 3-10-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones
Buffalo Mo

20. FILED 4-10 19 40 mm C. G. Reed
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-9, 1940

22. I HEREBY CERTIFY, That I attended deceased from 3-2-, 1940, to 3-9-, 1940

I last saw her alive on 3-8-, 1940. Death is said to have occurred on the date stated above, at 4:45 P.

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

Broncho-Pneumonia

Date of onset 5-8-40

Other contributory causes of importance: 10/11

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?

Where did injury occur?

Manner of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) R. E. Hanell, M. D.
Buffalo, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

50M-9-19-38 1 X16605

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.

RECEIVED

District Health Officer No. 7,

District File Number 4-40-658

Date Filed 4-12-40

OFFICE RECORDS

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10789

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 244

Primary Registration District No. 3338

Registrar's No.

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Jeppener
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Dallas
(c) City or town Placid Rural
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Anna Hess Paylan

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

12. Name Jobe Hess

13. Birthplace pa _____
(City, town, or county) (State or foreign country)

14. Maiden name Marquet Decker

15. Birthplace pa _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-10-46 (b) Mrs C & Reed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 3 day 9
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 R E Harrell (M. D. or other) _____

Address Buffalo _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

S-10789

1940

REPRODUCTION OF ORIGINAL RECORD