

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
931 north Sarah
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Linnell Lennie Cole Payne
3. (b) If veteran, name war no
3. (c) Social Security No. None

4. Sex Female 5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John Payne
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Dec 25 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 10 If less than one day hr. min.

9. Birthplace Miss (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____
12. Name Unknown
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 John Payne
(b) Address 931 no Sarah st
17. (a) Burial (b) Date thereof July 9-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director J. W. Hughes
(b) Address 2620 Lawton Blvd
19. (a) Jul 8 1940 (b) J. B. Baker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouria (b) County St Louis
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 931 No Sarah st (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5
year 1940 hour 9 minute A M.

21. I hereby certify that I attended the deceased from _____, 1940, to July 5, 1940, that I last saw her alive on July 4, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
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) (f) Means of injury _____
23. Signature W. O. New (M. D. or other)
Address 1415 S. Grand Date signed July 8/40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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

1 X 8511
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.

MOTHER BROTHER

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..... *Lyla Hughes*

Licensed Embalmer No. *2938*

P. O. Address..... *St Louis mo*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State File No. 23309.47
Local Registrar's No. 5754

State of _____ }
County of _____ } ss.

AFFIDAVIT FOR CORRECTION OF A RECORD

On this _____ day of _____, 194____, before me appears _____, who, upon _____ oath, states that the original record of ^{birth} death

for Tinnie Cole Payne died July 5-1940, 19____, in the State of Missouri, and which was filed at _____ on _____, 19____, should be corrected as follows:

Item No. 2 should read Tinnie Cole Payne

Instead of _____ Stennie Cole Payne

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant Maryel Undertaking Co. Fun Dir
Per - Beatrice Lopez Relationship.
4059 Finney Ave.
Present Address.

Subscribed and sworn to before me this 30 day of Aug, 1945

My Commission expires 3-4-53 Edw C. Johnson Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

No. 72 B
2-21-40
I X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23309**
Registrar's No. **2724**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(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 _____ (b) County _____
(c) City or town _____
(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 STENNIE Cole Payne
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

19. MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7 day 5
year _____ hour _____ minute _____ M.

4. Sex 7
5. Color col
6. (a) Single, widowed, married, divorced in
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased _____
(Month) (Day) (Year)

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

8. AGE: Years 69 Months 6 Days 10
If less than one day _____ hr. _____ min.

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

9. Birthplace _____
(City, town, or county) (State or foreign country)
10. Usual occupation _____
Industry or business _____
11. MOTHER FATHER
12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

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) 11-25-40 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

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)
(c) Means of injury _____
23. Signature H. B. De Pau (M. D. or other) _____
Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY