

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

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

SEP 11 1942

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

Do not use this space.

28028

1. PLACE OF DEATH

90 County St. Louis Registration District No. 746 90
 0 Township Central Primary Registration District No. 6981 0
 0 City St. Louis (No. 0) St. 0 Ward 0

2. FULL NAME Marjorie

(a) Residence, No. 0 St. 0 Ward 0
 (Usual place of abode)

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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 0

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hra. ormin.
	<u>1942</u>	<u>20 15</u>		

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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) 9

FATHER

13. NAME Donald Payne A.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 0

MOTHER

15. MAIDEN NAME Cliffie Ann Dean

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 0

17. INFORMANT James Payne
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Graceland DATE Feb 10 1942

19. UNDERTAKER James Payne
(ADDRESS)

20. FILED Nov 8 1942 Marjorie Wallington
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 15 1942

22. I HEREBY CERTIFY, That I attended deceased from 1942 to Feb 15 1942, 1942.
 I last saw him alive on Feb 15 1942, 1942. Death is said to have occurred on the date stated above, at 9:00 a.m.
 The principal cause of death and related causes of importance were as follows:

Acidosis ✓

Date of onset

Other contributory causes of importance:
Perennial Deaf ✓

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

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) J. R. Pottle _____, M. D.
 (Address) Carrollville

1194

RECEIVED

District Health Officer No. 5,

District File Number 942718

Date Filed 9.10-49

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28028

Registration District No. 746

Primary Registration District No. 5981

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Jackson
(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)

3. (a) PRINT FULL NAME No name
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
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 Months Days (If less than one day by year min)

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

10. Usual occupation.....

11. Industry of business.....

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)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... live on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death apoplexy Duration

Due to she heard beat but she chieft did not breath heart beat a few min.

Other conditions Borned dead
(include pregnancy within 3 months of death)

Major findings: Of operations 161a 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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

