

FILED SEP 23 1942 318
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **19 days** (Specify whether
In this community **23 years** years, months or days)

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

4. Sex **Female** 5. Color or race **Negro** 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 **Unknown** years
7. Birth date of deceased **September 8, 1892**
(Month) (Day) (Year)

8. AGE: Years **51** Months **50** Days **0** If less than one day
4 hr. min.

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

10. Usual occupation

11. Industry or business **Housework**

MOTHER FATHER { 12. Name **Frank Hicks**
13. Birthplace **Miss.** (City, town, or county) (State or foreign country)
14. Maiden name **Sylvia Unknown**
15. Birthplace **Miss.** (City, town, or county) (State or foreign country)

16. (a) Informant **Shirley M. Smith**
(b) Address **2601 N. Whittier St.**

17. (a) **Burial** (b) Date thereof **9 18 42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

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

(b) Address **3078 D Jackson**

19. (a) **SEP 16 1942** (b) **J. F. Budeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000**
(a) State **Missouri** (b) County **17**
(c) City or town **St. Louis,** **9 20**
(If outside city or town limits, write "RURAL")
(d) Street No. **2828a Howard** (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September** day **12,**
year **1942** hour **2** minute **30 P.** M.
21. I hereby certify that I attended the deceased from **August**
24, 19 **42** to **September 12,** 19 **42**
that I last saw him alive on **September 12,** 19 **42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive heart Disease with Renal Failure**
Duration **Unk.**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: 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?

(Specify type of place) While at work? (e) Means of injury **0**

23. Signature **J. E. Smith** (M. D. or other)
Address **2601 Whittier** Date signed **9/15/42**

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 Chas. L. Howell

Licensed Embalmer No. 245-2

P. O. Address 2834 Gamble

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, fact should be so stated above.