

FILED NOV 10 1943

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Franklin
 (b) City or town Sullivan
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
North Side, Sullivan, Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Six Weeks
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Crawford 28
 (c) City or town Bourbon, Mo.
 (If outside city or town limits, write "RURAL") J
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME George Washington Payne

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

4. Sex Male 5. Color or Race W 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Sarah Payne 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 7th. 1888
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 2 10 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name William J. Payne
 { 13. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Pollie Mitchell
 { 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant William Payne
 (b) Address Sullivan, Mo.

17. (a) Burial (b) Date thereof 10-31-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Road

18. (a) Signature of funeral director [Signature]
 (b) Address Sullivan, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27
 year 1943 hour 4 minute _____ A. M.
 21. I hereby certify that I attended the deceased from September 13th.
1943, to October 27th., 19 43.
 that I last saw him alive on October 27th., 19 _____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Coma Duration _____

Due to Chronic Nephritis

Due to _____

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

Major findings: 1312
 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) (2) Means of injury _____
 23. Signature Samuel Robertson (M. D. or other) _____
 Address North Side Hospital, Sullivan, Mo. Date signed 10/28/43

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 *J. Williams*
Licensed Embalmer No. 427
P. O. Address Sullivan, Mo.

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

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov.
Registrar's No. 32

Registration District No. 114 Primary Registration District No. 4186

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Sullivan
(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 (Specify whether _____)

3. (a) PRINT FULL NAME George W. Payne
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 w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 17- (Month) (Day) (Year)

8. AGE: Years 85- Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

(b) Address Sullivan, Mo

19. (a) Oct. 30, 1943 (b) Wilbert Williams
(Date received local registrar) (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 Oct. day 7
year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ 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)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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

34633