

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4600

Registrar's No. 1

FILED FEB 7 1945
Registration District No. 73845

Primary Registration District No. 4479

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

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Queen City
(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) 1

(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 Schuyler

(c) City or town Queen City
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country? 910 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mary C. Payton

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan., day 11
year 1944 hour 6, A. M. minute - M.

21. I hereby certify that I attended the deceased from Jan.,
2, 1944, to Jan. 10, 1944
that I last saw her alive on Jan. 10, 1944;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John Payton 6. (c) Age of husband or wife if
alive..... years

7. Birth date of deceased Feb. 6 1869
(Month) (Day) (Year)

Immediate cause of death..... Duration

Influenza, in an incomplete
paralysis.

Due to.....

Due to.....

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

8. AGE: Years Months Days If less than one day

74 11 5 hr. min.

Major findings:
Of operations.....

Of autopsy.....

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

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

10. Usual occupation house work

11. Industry or business.....

MOTHER FATHER { 12. Name Ira Roberts

{ 13. Birthplace not known
(City, town, or county) (State or foreign country)

{ 14. Maiden name Julia Starbuck
(City, town, or county) (State or foreign country)

{ 15. Birthplace not known
(City, town, or county) (State or foreign country)

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?

16. (a) Informant E. F. Roberts

(b) Address Queen City, Mo.

17. (a) burial (b) Date thereof Jan. 12, '44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fugate Cemetery

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

23. Signature J. O. Coffey (M. D. or other)
Address Queen City, Mo. Date signed 1-11-44

18. (a) Signature of funeral director Wm. G. West

(b) Address P.O. Box 277, Queen City, Mo.

19. (a) Jan. 12, 1944 (b) J. O. Coffey
(Date received local registrar) (Registrar's Signature)

1278 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 2-44-267

Date Filed FEB 5 1944

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 Wm H. West

....., Registered Apprentice No.

working under my personal supervision.

Signed Wm H. West

Licensed Embalmer No. 2882

P. O. Address Box 217 Lincen City OH

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.