DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 23 1944

Registration District No. 518

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 100

State File No. 20123

Registrar's No. 5498

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:
De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Dayes (Specify whether
In this community Life Time 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3611 Clarence
(If rural, give location)

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

3. (a) PRINT FULL NAME Corinne Payne

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William Payne

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased April (Month) 12 (Day) 1904 (Year)

8. AGE: Years 40 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name James Miles
13. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Maher
15. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant William Payne
(b) Address 3611 Clarence

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6)19)44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot Carroll
(b) Address 4600 Natural Bridge

19. (a) JUN 18 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16th year 1944 hour 8 minute 55 P.M.

21. I hereby certify that I attended the deceased from Jan. 15th 1939, to 1944 that I last saw her alive on June 16 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Congestive Heart Failure	6 mo.
Due to Rheumatic Heart Disease	
Due to	
Other conditions (Include pregnancy within 3 months of death) 95	

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

23. Signature D. B. Hanan (M. D. or other) M.D.
Address Humboldt Bldg. Date signed 6/17/44

(Licensed Embalmer's Statement on Reverse Side)

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 Sheldon Collie

Licensed Embalmer No. 3382

P. O. Address.....

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.