

No. 2
OM-5-43
v. 5-17-39
I X36671

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31083**
Registrar's No. **216**

FILED OCT 4 1944
Registration District No. **176**

Primary Registration District No. **5568**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Atherton Blue Twp.
(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 1
(Specify whether
 In this community 1
years, months or days)

3. (a) PRINT FULL NAME Robert S. Payton
 3. (b) If veteran, name war World War # 1
 3. (c) Social Security No. 495-03-8417

4. Sex Male 0 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Anna Payton
 6. (c) Age of husband or wife if alive 45 years
 7. Birth date of deceased February 3 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 6 Days 12
 If less than one day
 hr. min.

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

10. Usual occupation Deputy Collector

11. Industry or business U. S. Government

MOTHER FATHER {
 12. Name Allen S. Payton
 13. Birthplace Spencer Co. Indiana
(City, town, or county) (State or foreign country)
 14. Maiden name Anna Stevenson
 15. Birthplace Spencer Co. Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Payton
 (b) Address 431 North Eubank

17. (a) Burial (b) Date thereof 8-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) 8-18-1944 (b) James H. Ross
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **42**
 (c) City or town Independence **4**
(If outside city or town limits, write "RURAL") **4**
 (d) Street No. 431 North Eubank
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15
 year 1944 hour 3 minute 00 M.

21. I hereby certify that attended the deceased from Anna 19____
 that I last saw him alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Schistosomiasis
Chronic infectious hepatitis
acute pulmonary edema
 Due to _____
 Due to _____

Other conditions 938
(Include pregnancy within 3 months of death)

Major findings: 938
 Of operations _____
 Of autopsy See other

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 James H. Ross **3** 8/17/44
(M. or other) (Date signed)

1163

OCT 31 1945

OCT 10 1944

OCT 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *George C. Brown*

Licensed Embalmer No. *2249*

P. O. Address *Independence, Mo*

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.