

FILED MAR 8 1945
Registration District No. 122

Primary Registration District No. 5456

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield Wilson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community 34 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Rural Wilson Township
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 8 Springfield, Mo.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Marion Ralph Payne

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased August 26 1910
(Month) (Day) (Year)

8. AGE: Years 34 Months 5 Days 5 If less than one day
hr. min.

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

10. Usual occupation Farmer

11. Industry or business.....

MOTHER FATHER { 12. Name Walter Payne
13. Birthplace Greene Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name May Zittle
15. Birthplace Greene Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Walter Payne

(b) Address Route # 8 Springfield, Mo.

17. (a) Burial (b) Date thereof 2/3/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Patterson Cem.

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) Feb. 27-1945 (b) Glorence Britain
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1
year 1945 hour 2 minute a. M.

21. I hereby certify that I attended the deceased from Aug 1 1944 to January 31 1945
that I last saw him alive on January 30 1945
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration
Progressive Leontic Ataxia 2 yr

Due to.....

Due to.....

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

Major findings:
Of operations.....
Of autopsy.....
30a
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 E. M. Lelange M.D. (M. D. or other)

Address Brookline Station MO Date signed 2/2/45

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

RECEIVED

Greene County Health Office,

County File Number 45-3-21

Date Filed 3-6-45

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

Paul J. Brown

Licensed Embalmer No.

2457

P. O. Address

Greene

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 122

Primary Registration District No. 54561

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Springfield Rural
(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

3. (a) PRINT FULL NAME

Marian R. 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 5

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 34 Months 5 Days _____ If less than one day _____ min.

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

MOTHER FATHER { 10. Usual occupation _____

11. Industry or business _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 7 Day 22 Year 1945
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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)

Major findings: Of operations _____

Of autopsy _____

Duration

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

0157