. S. No. 2
0M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18489

Registration District No. 373 Primary Registration District No. 6265 Registrar's No. 34

1. PLACE OF DEATH:

(a) County Webster Co

(b) City or town Strafford Mo R.F.D. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Strafford Mo R.F.D. Grant Twp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Webster 1 0

(c) City or town Rural 0 (If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. Strafford Mo 0 (If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME IDA F. PAYTON

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex F 1

5. Color or race W

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

6. (b) Name of husband or wife John

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

7. Birth date of deceased Feb (Month) 9 (Day) 1880 (Year)

8. AGE: Years 65 Months 2 Days 23 If less than one day ___ hr. ___ min.

9. Birthplace Webster Co (City, town, or county) Mo. (State or foreign country) 1

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name George Willis
13. Birthplace N Carolina (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name Melissa Galbraith
15. Birthplace Tenn (City, town, or county) (State or foreign country) 1

16. (a) Informant Clifford Willis

(b) Address Northview Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive

18. (a) Signature of funeral director Rex Rainey

(b) Address Marshfield Mo

19. (a) May 17-45 (Date received local registrar) (b) Charlotte Bruce (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 2 year 1945 hour 12 AM minute 30 M.

21. I hereby certify that I attended the deceased from 1933, 19__, to 4/30, 1945 that I last saw her alive on 4/30, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Due to Chronic Nephritis	2
Due to Diabetes Mellitus	12 yrs.

Other conditions (Include pregnancy within 3 months of death)

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 0

23. Signature R. H. Foehtz (M. D. or other) M.D.

Address Strafford Mo Date signed 5/5/45

1344 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 645-664
Date Filed JUN 7 1945

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 Lex Lainey

Licensed Embalmer No. 3312

P. O. Address Marshfield 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.