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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 24 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15086

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3591

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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month (Specify whether
In this community 2 1/2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 22
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2642 a Chouteau
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert Lee Payne Sr.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 1 (Day) 1873 (Year)

8. AGE: Years 72 Months 11 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) Miss (State or foreign country)
10. Usual occupation Porter
11. Industry or business
FATHER 12. Name Robert Payne
13. Birthplace (City, town, or county) Miss (State or foreign country)
MOTHER 14. Maiden name Susie
15. Birthplace (City, town, or county) Miss (State or foreign country)
16. (a) Informant Amanda Mattie Brooks
(b) Address 2642 a Chouteau
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23/46 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem ~~Father Jackson~~
18. (a) Signature of funeral director F. A. Glen
(b) Address 2915 Franklin ave
19. (a) APR 19 1946 (Date received local registrar) J. F. Brezick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16 year 1946 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Mar. 15, 1946, to April 16, 1946; that I last saw him alive on April 16, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Basilar Meningitis Syphilitic	Unk
Due to	
Due to	
Other conditions: Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No

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. B. Williams (M. D. or other)
Address 2601 N Whittier Date signed 4/18/46

(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 K. G. Green

Licensed Embalmer No. 2963

P. O. Address 291 Franklin av

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.