

FILED FEB 10 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 4002

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Brushers Mo.  
(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 75 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair  
(c) City or town Brushers  
(If outside city or town limits, write "RURAL") \_\_\_\_\_  
(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EDWARD M. 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 W 2  
6. (b) Name of husband or wife Elnora Payne 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 1860  
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Orval Payne  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Elnora Kiggens  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F. P. Hasty  
(b) Address Brushers Mo.

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-47  
(Month) (Day) (Year)  
(c) Place: burial or cremation Brushers Cemetery

18. (a) Signature of funeral director F. R. Eastey  
(b) Address Brushers Mo.

19. (a) 1-29-47 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1  
year 1947 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from Dec 1st  
\_\_\_\_\_ 1946 to Dec 31, 1946

that I last saw him alive on Dec 31, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia of left foot.

Due to Teaming nail loose and retained  
Due to Trauma

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 H. M. Humphrey (M. D. or other) MD  
Address Brushers Mo. Date signed Jan 29 1947

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

MOTHER FATHER

021

AUG 1 1950

IMPAI. M. FRANCO

RECEIVED  
Public Health Officer No. 247-268  
FEB - 5 1947  
Date Filed

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 *Robert P. Embury*

Licensed Embalmer No. *1146*

P. O. Address *Trachler, 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.