

No. 2
4-13-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40617
State File No. _____
Registrar's No. 96

FILED DEC 15 1947
Registration District No. 233

Primary Registration District No. 3074

250
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(c) Name of hospital or institution Sikeston Gen. Hosp. 0
(d) Length of stay: In hospital or institution 14 years
In this community 14 years

3. (a) PRINT FULL NAME Birdie Paylor
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced M /
6. (b) Name of husband or wife Clyde Paylor
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased 11 13 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 0 8 hr. min.

9. Birthplace Knoxville Ark /
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {
12. Name Thomas Oakley 7
13. Birthplace Unknown 7
14. Maiden name Charity Manning
15. Birthplace Unknown 7

16. (a) Informant Winnie Paylor
(b) Address 414 Dorothy St. Sikeston, Mo

17. (a) Burial (b) Date thereof 11/23/47
(c) Place: burial or cremation Sikeston, Mo

18. (a) Signature of funeral director H. W. Albritton
(b) Address Sikeston, Mo

19. (a) 11-27-47 (b) Mrs. T. J. Payne
(Date received local registrar) (Registrar's signature) P.A.S.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott 107
(c) City or town Sikeston 5
(d) Street No. 414 Dorothy St 2
(e) If foreign born, how long in U. S. A.? no 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 21
year 1947 hour 4 minute P. M.
21. I hereby certify that I attended the deceased from 18 Nov 47
that I last saw her alive on 24 Nov 47
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis, Ch.
Due to Hypertensive Vascular Disease
Due to Acute Cholecystitis, Calc

Other conditions _____
Major findings: _____
Of operations _____
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature _____ (M. D. or other)
Address _____ Date signed 25 Nov 47

RECEIVED

District Health Office No. 2

District File Number 1247-1544

Date Filed 12-4-42

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.....

Licensed Embalmer No. 2961

P. O. Address Superior, Wis.

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.