

FILED OCT 21 1948

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

32349

State File No. _____

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 132

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

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
815 Isley Street /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether
In this community 21 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24
(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL") 1
(d) Street No. 815 Isley, Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EARL EUGENE PAYNE

3. (b) If veteran, name war Unknown 3. (c) Social Security No. 491-01-9255

4. Sex Maled 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased January 1, 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 9 8 hr. min.

9. Birthplace Woodford County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business None

MOTHER FATHER { 12. Name Benjamin Franklin
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Frances Leighton
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Stanley Payne

(b) Address Rt. 3, Liberty, Missouri

17. (a) Burial (b) Date thereof Oct. 12, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or removal xxxxx Keosauqua, Iowa

18. (a) Signature of funeral director Clayton Peichard

(b) Address Excelsior Springs, Missouri

19. (a) 10/12/48 (b) Kathleen Buttrick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9
year 1948 hour 2 minute 10 P.M.
21. I hereby certify that I attended the deceased from 9/27/48
to 10/9/48
that I last saw him alive on Oct 19 and that death occurred on the date and hour stated above.
Immediate cause of death Coronary Thrombosis Duration _____

Due to Chronic Myocardial Infarction
Anterior - 50%

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations none 12/16
Of autopsy none
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) no
(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 0

23. Signature H. A. Osborn (M. D. certifier)
Address Excelsior Springs, Mo Date signed 11/1/48

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 10-20-48.....

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 E. White

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs, 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.