

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42579

FILED JAN 24 1949  
Registration District No. 224

Primary Registration District No. 5860 Registrar's No. 8

1. PLACE OF DEATH:  
(a) County Oregon  
(b) City or town Koshkonong Myatt Twsp.  
(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 years, months or days) 3 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Oregon 75  
(c) City or town Koshkonong  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charity E. Payne  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 2  
year 1948 hour 11 minute 30 A.M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married? Widowed  
6. (b) Name of husband or wife Alfred Payne  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb. 18 1862  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 24  
1948 to Nov 25 1948  
that I last saw her alive on November 25 1948  
and that death occurred on the date and hour stated above.  
Immediate cause of death Circulatory Collapse Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
86 8 17 hr. min.

Due to Chronic Myocardial degeneration  
Due to Age and general debility  
Other conditions Chronic Nephritis 121B  
(Include pregnancy within 3 months of death)

9. Birthplace Tennessee  
(City, town, or county) (State or foreign country)  
10. Usual occupation Domestic

Major findings: Of operations 42 v. ?  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Wiley Crowell  
13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Turner  
15. Birthplace Tennessee  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mrs. Fred Mitchell  
(b) Address Koshkonong, Mo.  
17. (a) Burial (b) Date thereof 11/3/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Salem Cem.  
18. (a) Signature of funeral director Deland Carter  
(b) Address Thayer, Mo.  
19. (a) Jan 13-49 (b) Ella Crass 416  
(Date received local registrar) (Registrar's signature)

23. Signature Mitchell (Blawie) (M. D. or other) \_\_\_\_\_  
Address Manasseth Spring Creek Date signed 12-10-48  
While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_  
Blawie

~~\_\_\_\_\_~~  
Date Filed *6-28-11*  
District File Number *14952*  
District Health Officer No. *5*  
*RECEIVED 1-7-11*

**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.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**