

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39799**
04564

FILED DEC 12 1949

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Koch, Missouri)	c. LENGTH OF STAY (In this place) 23 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		d. STREET ADDRESS (If rural, give location) 1942nd Demerion	

3. NAME OF DECEASED a. (First) Goldie b. (Middle) - c. (Last) Payne			4. DATE OF DEATH (Month) (Day) (Year) 11-27-1949		
5. SEX Female		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 1-7-1912		9. AGE (In years last birthday) 37		10. IF UNDER 1 YEAR Months 10 Days 20 IF UNDER 14 HRS. Hours 11 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Nil		11. BIRTHPLACE (State or foreign country) St. Louis, Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A					

13a. FATHER'S NAME Roy Hudson		13b. MOTHER'S MAIDEN NAME Birdie Johnson		14. NAME OF HUSBAND OR WIFE Henry Payne	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNK		17. INFORMANT'S SIGNATURE OR NAME Record Koch Hospital	
(If yes, give war or dates of service)				ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis</p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>				INTERVAL BETWEEN ONSET AND DEATH 9mo & 7	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 602X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **11-4-49**, 19**49**, to **11-27-49** 19**49**, that I last saw the deceased alive on **11-27**, 19**49**, and that death occurred at **10:55 Am**, from the causes and on the date stated above.

23a. SIGNATURE Donald G. Russell (Degree or title) (M.D.)		23b. ADDRESS Koch Hospital		23c. DATE SIGNED 11-27-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-3-49		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County	
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DATE REC'D BY LOCAL REG. 12-1-49		REGISTRAR'S SIGNATURE Herbert H. Wouke		25. FUNERAL DIRECTOR'S SIGNATURE Bernie		ADDRESS 3103 Washington	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

According to our records secured from the patient she is 42 years old;
according to an affidavit sworn to by the mother the patient is 37 years old.

Harold J. Russell

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

H. Claude Gordon

Licensed Embalmer No. _____

3489

P. O. Address _____

4575 Aldine

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.