

STANDARD CERTIFICATE OF DEATH

19304

State File No.

FILED JUL 14 1951

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 192

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL, and give township) KIRKSVILLE c. LENGTH OF STAY (If this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) Nind Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Grim Smith Hosp.		d. STREET ADDRESS (If rural, give location) Kirkeville	

3. NAME OF DECEASED (Type or Print) Rhoda Payton	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) June 28 51
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5. SEX Female	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 17, 1870	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 Min. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Adair Co. Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas Hays	13b. MOTHER'S MAIDEN NAME Jance Cole	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Charles Payton ADDRESS Nind, Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis -		INTERVAL BETWEEN ONSET AND DEATH 10 years several yrs. 422H Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Arteriosclerosis		
	DUE TO (c) Carcinoma left lung.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (m.)	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 Feb 24, 1948, to June 28, 1951, that I last saw the deceased alive on June 28, 1951, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Shelton L. Freeman M.D. (Degree or title)	23b. ADDRESS Kirkeville, Mo.	23c. DATE SIGNED June 29, 1951
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24a. BURIAL, CREMATION, OR DISPOSAL (Specify) Burial	24b. DATE 6, 30. 51	24c. NAME OF CEMETERY OR CREMATORY Union Temple	24d. LOCATION (City, town, or county) (State) Nind, Mo
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DATE REC'D BY LOCAL REG. 7-8-51	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Dave Turner ADDRESS Home Kirkeville
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Date Received: JUL 1 1 1951
DISTRICT HEALTH OFFICE #2
District File Number 7-57-1846
Date Filed: JUL 1 2 1951

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

Donald L Roberts

Licensed Embalmer No. 4722

P. O. Address

Kirksville, Md

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.