

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27081

State File No. ....

FILED JUL 23 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 531 Registrar's No. 1919

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis County</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>University City</u> |  | c. LENGTH OF STAY (In this place) <u>4 1/2 yrs</u>   | c. CITY OR TOWN <u>Webster Groves</u> <u>4077</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christian Old Peoples Home</u>                           |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>                   |   |
| e. STREET ADDRESS (If rural, give location) <u>671 Tuxedo Blvd.,</u>                                |  | 0  |   |

|                                     |                       |                       |                        |   |
|-------------------------------------|-----------------------|-----------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Ida</u> | b. (Middle) <u>E.</u> | c. (Last) <u>Payne</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>July, 10, 1953</u> |
|-------------------------------------|-----------------------|-----------------------|------------------------|---|

|                 |                               |   |                                      |   |   |  |
|-----------------|-------------------------------|---|--------------------------------------|---|---|--|
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u> | 8. DATE OF BIRTH <u>Dec. 6, 1870</u> | 9. AGE (In years last birthday) <u>82</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 4 HRS. Hours _____ Min. _____ |
|-----------------|-------------------------------|---|--------------------------------------|---|---|--|

|   |   |   |  |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHING</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>teacher - SCHOOL</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Warren County, Iowa</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|---|---|--|

|  |   |   |
|--|---|---|
| 13a. FATHER'S NAME <u>Colson Payne</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah Ann Rhoads</u> | 14. NAME OF HUSBAND OR WIFE <u>none</u> |
|--|---|---|

|  |  |   |                                |
|--|--|---|--------------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Miss Julia May Lord,</u> | ADDRESS <u>6600 Washington</u> |
|--|--|---|--------------------------------|

|   |  |  |   |
|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u>   |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension arteriosclerosis</u><br>DUE TO (c) |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>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"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 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) | 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 July 9, 1953, to July 11, 1953, that I last saw the deceased alive on July 10, 1953 and that death occurred at 10:15 P.M., from the causes and on the date stated above.

|                                      |  |                                 |
|--------------------------------------|--|---------------------------------|
| 23a. SIGNATURE <u>J. Rogers M.D.</u> | (Degree or title) / 23b. ADDRESS <u>607 N. Grand</u> | 23c. DATE SIGNED <u>7-12-53</u> |
|--------------------------------------|--|---------------------------------|

|   |                                |   |  |
|---|--------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 24b. DATE <u>July 13, 1953</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Kirkwood Missouri</u> |
|---|--------------------------------|---|--|

|   |   |   |                                   |
|---|---|---|-----------------------------------|
| DATE REC'D BY LOCAL REG. <u>7-12-53</u> | REGISTRAR'S SIGNATURE <u>Herbert R. Dombke M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Shepard Funeral Home,</u> | ADDRESS <u>1167 Hamilton (12)</u> |
|---|---|---|-----------------------------------|

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

40064

---

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.....  
Signature of Student Embalmer

Signed.....  
*Fred J. Tanner*

Licensed Embalmer No. *4788*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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