

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37993**

FILED NOV 6 - 1953

BIRTH NO. _____		REG. DIST. NO. <b>333</b>		PRIMARY REG. DIST. NO. <b>3074</b>		Registrar's No. <b>116</b>	
1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sikeston, Mo.</b>		c. LENGTH OF STAY (In this place) <b>1 Day</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sikeston</b>		1003	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>517 Cleveland Drive</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Kenneth</b> b. (Middle) <b>Leon</b> c. (Last) <b>Payne</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>10 - -23 --1953</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Baby</b>	8. DATE OF BIRTH <b>3-18-1951</b>		9. AGE (In years last birthday) <b>2<sup>c</sup></b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b>	IF UNDER 2 HRS. Hours <b>5</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Sikeston, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Edward Leon Payne.</b>		13b. MOTHER'S MAIDEN NAME <b>Kathleen Welty</b>		14. NAME OF HUSBAND OR WIFE <b>—</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Leon Payne</b> ADDRESS <b>Sikeston, Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Peritonitis</b>	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Ruptured Appendix</b>						
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c)						
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		5501		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 <b>10-22, 1953</b> , to <b>10-23, 1953</b> , that I last saw the deceased alive on <b>10-23, 1953</b> , and that death occurred at <b>3:50 a.</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Alden P. Sargent M.D.</b>				23b. ADDRESS <b>Sikeston, Mo.</b>		23c. DATE SIGNED <b>10-23-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>10-25-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF MEMORIES</b>		24d. LOCATION (City, town, or county) (State) <b>SIKESTON MO</b>		
DATE REC'D BY LOCAL REG. <b>10-29-53</b>		REGISTRAR'S SIGNATURE <b>Mrs. Clara Hunter</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Welch Funeral Home Sikeston Mo</b>		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 2 1953

SCOTT COUNTY HEALTH CENTER

SCOTT  
CO. FILE NO. 1153-242

**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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Seaton

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.