

FILED MAR 4 1957

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 186-D

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Springfield</b> TOWN			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield 0396</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		Length of stay in lb <b>40 yrs</b>		d. STREET ADDRESS (If outside, give location) <b>2057 N. Grant</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WOODROW</b> Middle <b>PAYNE</b> Last <b>PAYNE</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>22,</b> Year <b>1957</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 24, 1893</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Frisco Freight Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frigo Dept.</b>		11. BIRTHPLACE (City and state or country) <b>Crocker, Missouri 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank Payne</b>				14. MOTHER'S MAIDEN NAME <b>Bebeca Carmack</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Peggy Payne, 2057 N. Grant</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Essential hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>331X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>			
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>2</b>						
20c. TIME OF INJURY Hour <b>9:15</b> Month <b>am.</b> Day <b>am.</b> Year <b>1955</b>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>at home</b>	
20f. CITY, TOWN, OR LOCATION <b>Springfield, Mo.</b>			COUNTY		STATE				
21. I attended the deceased from <b>1955</b> to <b>2-22-57</b> and last saw him alive on <b>2-21-57</b> Death occurred at <b>9:15 am.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>G. Hemmings MD</b> (Degree or title)				22b. ADDRESS <b>Springfield, Mo.</b>		22c. DATE SIGNED <b>2-22-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/25/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>					
24. FUNERAL DIRECTOR <b>AYRE-GOODWIN, Inc. Springfield</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>2-27-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>			

(Licensed Embalmer's Statement on Reverse Side)

300  
-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms will be listed. AN

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1937

**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.....  
*William T. Swadlow*

Licensed Embalmer No. *181*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.