

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13332

STATE FILE NUMBER  
1468

FILED APR 16 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1468

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Isadore Anderson

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> 1098 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>4529 Summit Street</b>		Length of stay in 1b <b>40 Years</b>	d. STREET ADDRESS (If outside, give location) <b>4529 Summit Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FLOYD</b> Middle <b>HENRY</b> Last <b>PAYNE</b>			4. DATE OF DEATH Month <b>March</b> Day <b>28th</b> Year <b>1957</b>
5. SEX <b>D</b> <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>June 10, 1887</b>
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk U. S. Post Office</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Johnson County Arkansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Payne</b>	
14. MOTHER'S MAIDEN NAME <b>Neita Jane Williams</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W. W. I</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Ina Payne, 4529 Summit K.C. Mo</b>	
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>Myasthenia Gravis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>May 1951</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>March 28, 1957</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____			
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>May 15, 1957</b> to <b>3-28-1957</b> last saw him alive on <b>3-28-1957</b> Death occurred at <b>3-28-57</b> at <b>1730 P.M.</b> of the above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Isadore Anderson M.D.</b> (Degree or title)		22b. ADDRESS <b>723 W 45<sup>th</sup> St</b>	22c. DATE SIGNED <b>3-28-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-30-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b> ADDRESS <b>K. C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-29-57</b>	26. REGISTRAR'S SIGNATURE <b>Norm Minshall</b>

APR 24 1957

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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 *Clayton A. Barnes*

Licensed Embalmer No. *479*

P. O. Address *F. C. M.*

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.