

X Health, & Welfare S. Public Health Service

S. 300 v. 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

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42237

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 6179 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Boytan</u> 1052
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 7b	d. STREET ADDRESS (If outside, give location) <u>1052</u>
3. NAME OF DECEASED (Type or print) <u>Robert Franklin Payne</u> First Middle Last			4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1932</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fillery Sta Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>25</u> IF UNDER 1 YEAR: Month <u>—</u> Days <u>—</u> IF UNDER 24 HRS.: Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (City and state or country) <u>Boytan - Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George J. Payne</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Grindstaff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 9-10-52 to 9-9-57</u>		16. SOCIAL SECURITY NO. <u>342-28-0999</u>	
17. INFORMANT <u>Josephine Payne - Boynton - Mo</u>		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) <u>crushed chest</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
20a. ACCIDENT <input checked="" 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.) <u>car upset</u>	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Mo. Hw. #5</u>	
20f. CITY, TOWN, OR LOCATION <u>Milan</u>		COUNTY <u>Sullivan</u> STATE <u>Mo</u>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>11:30 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. W. Simpson, D.O.</u>		22b. ADDRESS <u>Milan</u>	
22c. DATE SIGNED <u>11/29/57</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-1-1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cem.</u>		23d. LOCATION (City, town, or county) <u>Boytan - Mo</u>	
24. FUNERAL DIRECTOR <u>Schoepes</u> <u>August Schoepes</u>		25. DATE RECD. BY LOCAL REG. <u>12-2-57</u>	
ADDRESS		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>	

(Licensed Embalmer's Statement on Reverse Side)

DEC 12 1957

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..... *Dwight Schoene* .....

Licensed Embalmer No. *246*

P. O. Address *Neelan - W*

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.