t. Health,
, & Welfare
S. Public
th Service

S. 300
v. 1-57

FILED DEC 19 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 46194

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11545

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSP. #1. Length of stay in 1b 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN St. Louis. Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1213 N. 7th St. Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First JAMES Middle M. Last PAYTON

4. DATE OF DEATH Month NOV. Day 30, Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 21, 1892
9. AGE (In years last birthday) 65
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Advertising
11. BIRTHPLACE (City and state or country) Piedmont, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME James I Payton
13b. MOTHER'S MAIDEN NAME Lura E. Brown
14. NAME OF HUSBAND OR WIFE Bess M. Payton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. #2
16. SOCIAL SECURITY NO. 429-05-1967A
17. INFORMANT Bess M. Payton, 1213 N. 7th St. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) DELERIUM TREMENS
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 2 Wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 307X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11/14/57, to 11/30/57 and last saw her/him alive on 11/30/57
Death occurred at 2:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert F. Owen, M.D. (Degree or title)
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 11/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11-30-57
23c. NAME OF CEMETERY OR CREMATORY Local
23d. LOCATION (City, town, or county) (State) Piedmont, Missouri.

24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington, Blvd.
25. DATE RECD. BY LOCAL REG. DEC 2 57
26. REGISTRAR'S SIGNATURE J. Carl Smith MD
MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. 3653

P. O. Address St Louis 8 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.