

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016609
STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 173

300
1-57

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		c. CITY OR TOWN Green City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Grim Smith Memorial INSTITUTION		d. STREET ADDRESS 8 mi. SW Green City	
3. NAME OF DECEASED (Type or print) First John Middle Frazier Last Payne		4. DATE OF DEATH Month June Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1902
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (City and state or country) Milan, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas E. Payne	
13b. MOTHER'S MAIDEN NAME Lola G. Frazier		14. NAME OF HUSBAND OR WIFE Hazel G. Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 499-20-0827	
17. INFORMANT Mrs. Hazel Payne, Green City, Mo.		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) Acute coronary thrombosis.			INTERVAL BETWEEN ONSET AND DEATH 12 hours.
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)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 6-1-59 to 6-1-59 and last saw ^{her} him alive on 6-1-59 Death occurred at 11:20 p on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J.B. Jones, M.D.</i> (Degree or title)		22b. ADDRESS Kirksville, Missouri	22c. DATE SIGNED 6-5-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Green City Cemetery	23d. LOCATION (City, town, or county) (State) Green City, Mo.
24. FUNERAL DIRECTOR Sharon E. Hart & Son, Green City, Mo.		25. DATE RECD. BY LOCAL REG. 6-9-1959	26. REGISTRAR'S SIGNATURE <i>Deris W. Ratliff</i>

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FEB 4 1960

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 *Karl R. Kent*

Licensed Embalmer No. *4689*

P. O. Address *Green City, 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.