

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016850

STATE FILE NUMBER 504

FILED MAY 18 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

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1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp #2		Length of stay in lb 20 years	3118 d. STREET ADDRESS (If outside, give location) 1201 Washington
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Silas Payne			4. DATE OF DEATH Month Day Year May 11, 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1930	9. AGE (In years last birthday) 19	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	11. BIRTHPLACE (City and state or country) Chattanooga Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Lindsay Payne		13b. MOTHER'S MAIDEN NAME Ellen Arnold		14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Felton T. Payne, 2002 N. 13, Kansas City Mo.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Deceased Heart General Arteriasclerosis		INTERVAL BETWEEN ONSET AND DEATH Chronic 10 years
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) Psychotic		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 o.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
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21. I attended the deceased from Jan. 1, 1959 to May 11, 1959 and last saw him alive on May 10, 1959  
Death occurred at 5 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE G. E. Cousins M.D.	(Degree or title)	22b. ADDRESS State Hosp #2 St. Joseph, Mo.	22c. DATE SIGNED 5-11-1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE May 12, 1959	23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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24. FUNERAL DIRECTOR H. O. Sidenfaden & Son N. W. D.	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. May 12, 1959	26. REGISTRAR'S SIGNATURE Mira Clark Woodell
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(Licensed Embalmer's Statement on Reverse Side)

Dr. G. E. Cousins  
 All diseases in Part I must be causally related.  
 Doctor, coroner, etc.: must use only standard nomenclature in terms of symptoms with or without  
 MEDICAL CERTIFICATION  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 ..... *N. William Davis* .....

Licensed Embalmer No. .... *4195* .....

P. O. Address. .... *St. Joseph, 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.