

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022031

STATE FILE NUMBER

FILED JUN 30 1959

Registration District No. 172

Primary Registration District No. 2034

Registrar's No. 53

300
-57

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1. PLACE OF DEATH a. COUNTY LAFAYETTE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LAFAYETTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HIGGINSVILLE		c. CITY OR TOWN HIGGINSVILLE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR SCHLEICHER REST HOME		d. STREET ADDRESS (If outside, give location) 1906 WALNUT	

3. NAME OF DECEASED (Type or print) First THOMAS Middle YOUNG Last PAYNE	4. DATE OF DEATH Month JUNE Day 8 Year 1959
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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 JULY 6 1874	9. AGE (In years last birthday) 84	10. FUNDER 1 YEAR Months 11 Days 3	11. IF UNDER 24 HRS. Hours 3 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) LAFAYETTE CO. MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME C. H. PAYNE	13b. MOTHER'S MAIDEN NAME SALLY AMBROSE	14. NAME OF HUSBAND OR WIFE MAMIE H. PAYNE
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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. ---	17. INFORMANT MARION F. PAYNE Address HIGGINSVILLE MISSOURI
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET OF DEATH 24 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arterio-sclerotic Hypertension		Years -
	DUE TO (c) Generalized Arteriosclerosis		Years =
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X		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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from March 1950 to June 8-59 and last saw ^{her} him alive on June 1-59 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. Kopp (Degree or title) MD	22b. ADDRESS Higginsville, Mo	22c. DATE SIGNED June 18-59
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23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE JUNE 10 1959	23c. NAME OF CEMETERY OR CREMATORY CITY CEMETERY	23d. LOCATION (City, town, or county) (State) HIGGINSVILLE MISSOURI
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24. FUNERAL DIRECTOR A.H. HADER, FUNERAL HOME ADDRESS HIGGINSVILLE MISSOURI BY A. H. Hader	25. DATE RECD. BY LOCAL REG. June 23.59	26. REGISTRAR'S SIGNATURE Lucie Jordan Jordan
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All diagnoses in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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, ~~_____~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Wm. L. Thurman

Licensed Embalmer No. 4563
P. O. Address Richardson, 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.