

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025594

FILED VS AUG 4 1959

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 166

DED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Plouville</u>		Length of stay in 1b <u>1954</u>		c. CITY OR TOWN <u>Near Buckner, Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson Co. Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Little Blue, mo.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice M. Payne</u>				4. DATE OF DEATH Month Day Year <u>7-18-59</u>					
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-07-95</u>		9. AGE (last birthday) Months Days Hours Min. <u>7 14</u>	IF UNDER 1 YEAR <input checked="" type="checkbox"/>	IF UNDER 24 HR <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (City and state or country) <u>Jackson Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		
13a. FATHER'S NAME <u>unknown</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Record Jackson Co. Home</u>				
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>Cardiac Renal</u> DUE TO (b) <u>71 yr hepatitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 1b.)					
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 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 <u>7-1-59</u> to <u>7-18-59</u> and last saw her/him alive on <u>7-18-59</u> Death occurred at <u>2:10</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>S. L. Griffin MD</u>				22b. ADDRESS <u>R. #4 Independence, Mo</u>				22c. DATE SIGNED <u>7-21-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>7-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cme.</u>		23d. LOCATION (City, town, or county) (State) <u>Independence, Mo</u>				
24. FUNERAL DIRECTOR ADDRESS <u>C. E. Davis K.C. Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7/21/59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lee Davis

Licensed Embalmer No. 4417
P. O. Address N. E. Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.