

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032519

FILED VS SEP 25 1959 / 49

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 4388 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>40 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If in hospital, give hospital or institution) <b>Malotta Nursing 3217 Cleveland</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3347 Gillham Rd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Victor</b> Middle <b>V.</b> Last <b>Payne</b>			4. DATE OF DEATH Month <b>9</b> Day <b>6</b> Year <b>1959</b>	
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5. SEX <b>Male</b>	6. COLOR OF RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10. KIND OF BUSINESS OR INDUSTRY <b>Sunshine Biscuit</b>	11. BIRTHPLACE (City and state or country) <b>Ashland Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>R.L. Payne</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Nichols</b>	14. NAME OF HUSBAND OR WIFE <b>Lucy Payne</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>487 10 7654</b>	17. INFORMANT <b>Nina Nelson 9001 E. 52 Terr Raytown Mo.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b>		<b>3 da.</b>
DUE TO (b) <b>Myocardial Repermeation</b>		<b>is do</b>
DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		<b>years</b>
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 type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **1956** to **1959-9-6** and last saw her/him alive on **July 59**  
Death occurred at **1100 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Dr. La Rue</b>	22b. ADDRESS <b>5811 Mansfield Rd Mo</b>	22c. DATE SIGNED <b>9-9-59</b>
23a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/9/ 1959</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Floral Hills</b>
23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>		

25. DATE RECD. BY LOCAL REG. <b>9-9-59</b>	26. REGISTRAR'S SIGNATURE <b>Wes Marshall</b>
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BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION La Rue

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

*Forest D Coldman*

Licensed Embalmer No.

*4714*

P. O. Address

*KC Mo*

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.