

BURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033089

FILED VS SEP 22 1959

Registration District No. 210 Primary Registration District No. _____ Registrar's No. 48 STATE FILE NUMBER

MEMENDED

1. PLACE OF DEATH a. COUNTY <u>Merces</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Princeton</u> Length of stay in 1b <u>1 day</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u> c. CITY OR TOWN <u>Milan</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS _____ (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman Lane Payne</u>			4. DATE OF DEATH Month Day Year <u>9 - 15 - 59</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1876</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>16</u>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Milan - Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Caleb Payne</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Lane</u>		14. NAME OF HUSBAND OR WIFE <u>Katherine Gardner</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. _____		17. INFORMANT Address <u>Kate Payne - Milan Mo</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 Arrest</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 Year</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Arteriosclerosis</u>		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		
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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 _____ 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 Sept 15 to Sept 15 and last saw him alive on Sept 15
 Death occurred at 12:30 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. Hartman MD</u>	22b. ADDRESS <u>301 W. North Farmington Mo</u>	22c. DATE SIGNED <u>15 Sept 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Milan Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Dwight Schoone Milan Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-17-59</u>	26. REGISTRAR'S SIGNATURE <u>Stall Smith</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan, 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.