

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 31 1960

**=60-029660**  
STATE FILE NUMBER

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Boone</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Length of stay in lb <u>3yr8mo</u>		c. CITY OR TOWN <u>Centralia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Campbell House</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>117 S. Hickman</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Curtis</u> Middle <u>Payne</u> Last <u>Payne</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</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>3/9/83</u>		9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ashland, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Thomas Payne</u>				13b. MOTHER'S MAIDEN NAME <u>Ellen Stewart</u>				14. NAME OF HUSBAND OR WIFE <u>deceased</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 <u>Mildred Campbell, Centralia, Mo.</u> Address							
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 <u>2 1/2 hrs</u> <u>few years</u>			
IMMEDIATE CAUSE (a) <u>Aspirate Pneumonia</u>													
DUE TO (b) <u>Exhaustion of Old age</u>													
DUE TO (c) <u>AD</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of Tongue</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			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u></u> Month <u></u> Day <u></u> Year <u></u> p.m. <u></u>													
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>9-20-57</u> to <u>8-24-60</u> and last saw him alive on <u>8-23-60</u> Death occurred at <u>11:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>P. Baker MD</u>				22b. ADDRESS <u>Centralia MO</u>				22c. DATE SIGNED <u>8-26-60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 27 '60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centralia</u>		23d. LOCATION (City, town, or county) <u>Centralia, Mo.</u>		(State)					
24. EMBALMER'S NAME <u>Clayton Neeson</u>				25. DATE RECD. BY LOCAL REG. <u>Aug. 27-1960</u>		26. REGISTRAR'S SIGNATURE <u>Maud M. Bride</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

*Bill J. Mendro*

Licensed Embalmer No. 4874

P. O. Address Centelia, La.

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