

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004738

STATE FILE NUMBER

AMENDED

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 39

FILED VS FEB 21 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Callaway</u>	a. STATE <u>Missouri</u> COUNTY <u>Callaway</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Length of stay in 1b <u>40 days</u>	c. CITY OR TOWN <u>Fulton</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>312 W. 2nd St.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>301 W. 5th St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Daniel</u>	Middle <u>Pollard</u>	Last <u>Payne</u>	4. DATE OF DEATH	Month <u>Feb.</u>	Day <u>10</u>	Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>1/14/1877</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage & Harrison Walker Refractories</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hams Prairie, Mo</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James A. Payne</u>	13b. MOTHER'S MAIDEN NAME <u>Robert Ella Payne</u>	14. NAME OF HUSBAND OR WIFE <u>Alfa Lynes Payne</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. A. W. Griffith, Fulton, Mo</u>	Address
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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) <u>Arterio sclerotic Cardiovascular disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebrovascular accident Nov '60; Right Femoral Embolus Dec '60</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.)
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20c. TIME OF INJURY Hour _____, Minute _____, 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
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21. I attended the deceased from <u>Nov 1960</u> to <u>Present</u> and last saw her alive on <u>Feb 6, 1961</u>	Death occurred at <u>3:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>James S. Hill MD</u>	22b. ADDRESS <u>Fulton, Mo</u>	22c. DATE SIGNED <u>2-13-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 12, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Callaway Memorial Gardens</u>	23d. LOCATION (City, town, or county) <u>Fulton</u>	(State) <u>Mo</u>
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24. FUNERAL DIRECTOR <u>Wallace Funeral Home, Fulton, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Feb-13-1961</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

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 *A.P. Maxine*

Licensed Embalmer No. 4996
P. O. Address Fulton, 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.