

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-048649

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12667 STATE FILE NUMBER

FILED JAN 10 1963

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

1 2/10
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13 71

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Sa int Louis, Missouri				c. CITY OR TOWN		Saint Louis									
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION		The Peoples Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		4461 Elmbank Avenue									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year								
Ada			Payne			December 30, 1962											
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR.					
Female		Negro				7-8-1893		69		Months Days		Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY					
HOUSEWIFE				NONE				Clarksdale, Mississippi				U.S.A.					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
Sherman Robinson				FRANCIS SLEDGE				Boston Payne									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
No				UNKNOWN				BOSTON PAYNE				4461 EIMBANK					
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)										1 day							
Cerebral Thrombosis										several years							
DUE TO (b)																	
Arteriosclerosis																	
DUE TO (c)										332x							
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 18.)													
20c. TIME OF INJURY		Hour 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 12-17-62 to 12-30-62 and last saw her/him alive on 12-30-62																	
Death occurred at 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE						22b. ADDRESS				22c. DATE SIGNED							
Bernard C. Randolph, M.D.						4903a, Easton				12-31-62							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)									
BURIAL		1-4-63		OAKDALE CEMETERY				LEMAY COUNTY, MO.									
24. FUNERAL DIRECTOR					ADDRESS					25. DATE RECD. BY LOCAL REG.				26. REGISTRAR'S SIGNATURE			
McCLAIN					1841 CASS AVE					JAN 2 1963				Rogert Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

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

Wallace R. Williams

Licensed Embalmer No. 4926

5135 Latus
P. O. Address

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.