

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034791

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 203 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 28 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Scott</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston Length of stay in 1b 3 1/2 hours</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. DELTA COMMUNITY HOSP. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Missouri b. COUNTY Scott</p> <p>c. CITY OR TOWN Oran Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Rt. #1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year</p> <p style="text-align: center;">Thurman Payne August 11, 1963</p>	
<p>5. SEX Male 6. COLOR OR RACE Negro 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH 8-11-63 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR</p> <p style="text-align: right;">Months Days Hours Min. 9 30</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10b. KIND OF BUSINESS OR INDUSTRY ---</p> <p>11. BIRTHPLACE (City and state or country) ORAN, SCOTT, MO. 12. CITIZEN OF WHAT COUNTRY USA</p>	
<p>13a. FATHER'S NAME U.C. PAYNE 13b. MOTHER'S MAIDEN NAME ESSIED HUNTER 14. NAME OF HUSBAND OR WIFE ---</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates) 16. SOCIAL SECURITY NO. 17. INFORMANT Address U.C. PAYNE (FATHER)</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abnormal Pulmonary Ventilation INTERVAL BETWEEN ONSET AND DEATH 9 1/2 hrs.</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. Prematur. by (30-32 wks)</p> <p>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</p>	
<p>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.)</p>	
<p>20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.</p>	
<p>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</p>	
<p>21. I attended the deceased ON 8-11-63 to 3:30 PM and last saw her/him alive on 8-11-63. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) Audra B. Smith MD 22b. ADDRESS Sikeston, Mo. 22c. DATE SIGNED 8-13-63</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE Aug. 12 1963 23c. NAME OF CEMETERY OR CREMATORY McMullan 23d. LOCATION (City, town, or county) (State) Scott County Mo</p>	
<p>24. FUNERAL DIRECTOR ADDRESS Earl J. Smith F. H. Oran, Mo. 25. DATE RECD. BY LOCAL REG. August 17 1963 26. REGISTRAR'S SIGNATURE Jeanette Waldman</p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

REGULAR RESIDENCE (Town or city, county and state)

SEX M F

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{NOT} embalmed by me, or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Earl J. Smith

Licensed Embalmer No. 3676

P. O. Address Oregon, 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.

No permit issued