

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Moniteau  
Township Harrison Registration District No. 576 File No. 8006  
or Village High Point Mo. Primary Registration District No. 5773 Registered No. One  
or City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Siborah H. Payne

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widow  
(Write the word)

DATE OF BIRTH Nov 12, 1827  
(Month) (Day) (Year)

AGE 92 yrs. 3 mos. 7 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE  
(City or town, State or foreign country) New York

PARENTS  
NAME OF FATHER Jeremiah Hardenburg  
BIRTHPLACE OF FATHER unknown  
(City or town, State or foreign country)  
MAIDEN NAME OF MOTHER Crowell  
BIRTHPLACE OF MOTHER unknown  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. H. Payne  
(ADDRESS) High Point Mo.

Filed 3-10 1920 W. H. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 19, 1920  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 18, 1920, to July 19, 1920, that I last saw him alive on July 18, 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:  
Senility  
162 154  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) G. B. Glover M. D.  
2-23 1920 (Address) Russellville Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Woodman Cemetery DATE OF BURIAL Febr 20, 1920

UNDERTAKER E. C. Nitebury ADDRESS California Mo

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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City \_\_\_\_\_  
 Registration District No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_  
 File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_  
 COLOR OR RACE \_\_\_\_\_  
 SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_  
 WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_  
 (Write the word)  
 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_, 191\_\_\_\_ (Year)  
 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. if LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION \_\_\_\_\_  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE \_\_\_\_\_  
 (City or town, State or foreign country)

NAME OF FATHER \_\_\_\_\_  
 BIRTHPLACE OF FATHER \_\_\_\_\_  
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER \_\_\_\_\_  
 BIRTHPLACE OF MOTHER \_\_\_\_\_  
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_, REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_, 191\_\_\_\_ (Year)  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_  
 that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_  
 and that death occurred, on the date stated above, at \_\_\_\_\_ in.  
 The CAUSE OF DEATH was as follows:

Contributory \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted if not at place of death?  
 Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_