

4-13-40
-17-39
X23159

STANDARD CERTIFICATE OF DEATH

State File No. **31330**

FILED OCT 11 1940

Registration District No. _____

Primary Registration District No. **3004**

Registrar's No. **71**

1. PLACE OF DEATH

(a) County **Bates**
(b) City or town **Butte**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Butte Memorial Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether
In this community **72 years**
years, months or days)

3. (a) PRINT FULL NAME **HERBERT A WAYLAND**

3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

4. Sex **in** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **married**

(b) Name of husband or wife **Lorraine Wayland** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **May 2 1865**
(Month) (Day) (Year)

8. AGE: Years **75** Months **3** Days **29** If less than one day hr. _____ min. _____

9. Birthplace **Virginia**
(City, town or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business _____

12. Name **Henry Wayland**

13. Birthplace **Virginia**
(City, town or county) (State or foreign country)

14. Maiden name **Mary Brown**

15. Birthplace **Virginia**
(City, town or county) (State or foreign country)

16. (a) Informant **Mrs. Lorraine Wayland**
(b) Address **Butte, Mo.**

17. (a) **Burial** (b) Date thereof **Sept 3 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rego's Cemetery**

18. (a) Signature of funeral director **W. L. Culver**
(b) Address **Butte, Mo.**

19. (a) **Sept 3 1946** (b) **Wm L Culver**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Bates**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Summit Twp. Bates Co.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **1**
year **1940** hour **2** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **Aug 16**, 19**40** to **Sept 4**, 19**40**
that I last saw him alive on **Sept 4** at **Butte**
and that death occurred on the date and hour stated above.

Immediate cause of death **Strangulated Intestinal Hernia**

Due to **Intestinal Obstruction**

Due to _____
Other condition **Carcinoma sigmoid**
(include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **46**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

53 While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Wm L Culver** (M. D. or other) **MD**
Address **Butte, Mo** Date signed **9/2/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 7,
District File Number 10-40-1466
Date Filed 10-10-40

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, ~~myself~~.....
....., Registered Apprentice No.
working under my personal supervision.

Signed *R. Stanton Lisc...*
Licensed Embalmer No. 4123
P. O. Address Butler, 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 this body is not embalmed, fact should be so stated above.