

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1949

State File No. **37987**

BIRTH NO. _____		REG. DIST. NO. <b>209</b>		PRIMARY REG. DIST. NO. <b>3043</b>		Registrar's No. <b>420</b>	
1. PLACE OF DEATH a. COUNTY <b>Marion</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Hannibal</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>Hannibal</b>		d. STREET ADDRESS (If rural, give location) <b>616 Center St</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Levering Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>616 Center St</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Beau Ford</b> b. (Middle) <b>T.</b> c. (Last) <b>Wayne Sr.</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 24, 1949</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 5, 1869</b>	
9. AGE (In years last birthday) <b>80</b>		10. MONTHS <b>10</b>		11. DAYS <b>19</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.R. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C.B.Q.P.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Sturgeon, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Archibald Wayne</b>			13b. MOTHER'S MAIDEN NAME <b>Lena</b>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Francis Brice</b> ADDRESS <b>614 Center Hannibal MO</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Aluekemic lymphatic leukemia</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <b>2040</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>12-28-48</b> , to <b>11-24-49</b> , that I last saw the deceased alive on <b>11-24-49</b> , and that death occurred at <b>12:45 P.</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>J. L. Green</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>100 N. Sixth, Hannibal, Mo.</b>		23c. DATE SIGNED <b>11-28-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11-26-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Grandview Burial Park</b>		24d. LOCATION (City, town, or county) (State) <b>Hannibal Marion Mo</b>	
DATE REC'D BY LOCAL REG. <b>12-7-49</b>		REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke</b>		FUNERAL DIRECTOR'S SIGNATURE <b>James O'Donnell</b>		ADDRESS <b>Hannibal Mo</b>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORDING

RECEIVED DEC 8 1949  
MARION CO. HEALTH DEPT.  
DATE FILED DEC 10 1949

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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 .....  
Student Embalmer

Signed Michael J. O'Connell

Licensed Embalmer No. 3246

P. O. Address Hannibal 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.