S. No. 300
v: 10-48

FILED JUL 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20537

State File No. .....

BIRTH NO. ..... REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2826

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
c. LENGTH OF STAY (In this place) 52 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 130 East Linwood

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
d. STREET ADDRESS (If rural, give location) 130 East Linwood Blvd.

3. NAME OF DECEASED (Type or Print) a. (First) Russell b. (Middle) J. c. (Last) Wayman

4. DATE OF DEATH (Month) (Day) (Year) 6-23-50

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 9-27-86
9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S SIGNATURE OR NAME Moses Goodman ADDRESS 4114 Oak

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause of death unknown

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.

INTERVAL BETWEEN ONSET AND DEATH

7955

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from ....., 19...., to ....., 19...., that I last saw the deceased alive on ....., 19...., and that death occurred at ..... m., from the causes and on the date stated above.*

23a. SIGNATURE Geo. C. Kealhofer (Degree or title) Geo C Kealhofer M.D. & Deputy Coroner
23b. ADDRESS 3447 Prospect K C Mo
23c. DATE SIGNED 6-26-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-27-50
24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary
24d. LOCATION (City, town, or county) (State) Kansas City, Kan.

DATE REC'D BY LOCAL REG. 6-26-50
REGISTRAR'S SIGNATURE Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE B. E. Weibert ADDRESS K.C. 8, Mo.

(Licensed Embalmer's Statement on Reverse Side)

MAR 2 1962

MAR 2 1962

VS 1 1962

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 Blaine E. Weilert

Licensed Embalmer No. 14075

P. O. Address L.C. 8, 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.