

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **328**
Registrar's No. **135**

BIRTH NO. **FILED FEB 15 1954** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

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

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY Andrew					
b. CITY OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 3 DAYS	c. CITY OR TOWN SAVANNAH		d. STREET ADDRESS (If rural, give location) 0020 /			
d. FULL NAME OF HOSPITAL OR INSTITUTION Leon Nursing Home 624. Prospect Lane			d. STREET ADDRESS (If rural, give location)					
3. NAME OF DECEASED (Type or Print) Adelaide			a. (First)	b. (Middle) WAYLAND	c. (Last)			
4. DATE OF DEATH		(Month)	(Day)	(Year)				
2-7-1954		2	7	1954				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 1-22-1863	9. AGE (in years last birthday) 91	if UNDER 1 YEAR Months 0	if UNDER 12 HRS. Days 15	if UNDER 12 HRS. Hours 	if UNDER 12 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and State or Foreign Country) Kittering Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Edward Schmidt		13b. MOTHER'S MAIDEN NAME Mary Dudley		14. NAME OF HUSBAND OR WIFE John L. Wayland				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. W. L. Smith ADDRESS SAVANNAH MO				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure			ANTECEDENT CAUSES			4 1/8 hrs		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			DUE TO (b) Senility					
			DUE TO (c) Senile Arteriosclerosis					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4500				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)				
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 2/6, 1954 to 2/7, 1954 that I last saw the deceased alive on 2/6, 1954 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above.								
23a. SIGNATURE Leda C. Benson (Degree or title) N.D.			23b. ADDRESS 510 Corny Bldg			23c. DATE SIGNED 2/8/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2-9-1954	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph MO.			
DATE REC'D BY LOCAL REG. Feb 8, 1954		REGISTRAR'S SIGNATURE Kathleen M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE Breit Funeral Home ADDRESS SAVANNAH MO				

FEB 18 1959

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.