

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41632

State File No.

FILED JAN 5 - 1956

BIRTH NO. _____ REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 4427 Registrar's No. 189

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Waynesville Rt #2</u>		c. CITY OR TOWN <u>Waynesville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>15 Day</u>		e. STREET ADDRESS (If rural, give location) <u>Rural Rt #2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Waynesville General Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Donald</u>	b. (Middle) <u>Lee</u>	c. (Last) <u>Wayman</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 24 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Jan 30, 1940</u>	9. AGE (In years last birthday) <u>15</u>	# MONTHS <u>10</u>	# DAYS <u>26</u>	# HOURS & MIN. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Pulaski County Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>George Walter Wayman</u>	13b. MOTHER'S MAIDEN NAME <u>Gladys Kelley</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Thomas Wayman</u>	ADDRESS <u>Rolla Missouri</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Nasopharyngeal Carcinoma</u>		
	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.		<u>146X</u>	

19a. DATE OF OPERATION <u>1955</u>	19b. MAJOR FINDINGS OF OPERATION <u>Biopsy lymph node neck - metastatic carcinoma</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 Feb, 1955, to Dec, 1955, that I last saw the deceased alive on Dec, 1955, and that death occurred at 11 A. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R D Musser, MD</u>	23b. ADDRESS <u>Waynesville Missouri</u>	23c. DATE SIGNED <u>Dec 25 55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12/26/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Waynesville Memorial Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Waynesville Missouri</u>
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DATE REC'D BY LOCAL REG. <u>12-26-55</u>	REGISTRAR'S SIGNATURE <u>Gaula Mae Anderson</u>	458	5. HEALTH DIRECTOR'S SIGNATURE <u>Billy W. Anderson</u>	ADDRESS <u>WELLES GENERAL HOMES INC WAYNESVILLE MISSOURI</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

10.300
10.48

APPROVED 12-26-55
Date Filed 12-21-55
The Number
COUNTY HEALTH OFFICER

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
Signature of Student Embalmer

Signed *Clarence Stross*

Licensed Embalmer No. 489

P. O. Address *Waynes*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.