

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **526**  
Registrar's No. **3000**

FILED JAN 14 1957

Registration District No. **1** Primary Registration District No. **3000**

1. PLACE OF DEATH a. COUNTY <b>Adair</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Kirksville</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>S-Boundry St.</b>			Length of stay in lb <b>17 years</b>		d. STREET (If outside, give location) ADDRESS <b>1408-N-Green</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Don E. Wayman</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>1</b> Year <b>1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1908</b>			
9. AGE (In years last birthday) <b>48</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dairy Supply Sales</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Whol. Dist.</b>		11. BIRTHPLACE (City and state or country) <b>Greentop., Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>W. I. Wayman</b>				14. MOTHER'S MAIDEN NAME <b>Julia Norman</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Don Wayman, 1408-N-Green, <b>Kirksville, Mo</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Anoxia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>Cerebral thrombosis</b>		DUE TO (c) <b>Arteriosclerotic heart disease</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>12:50 A</b> Month <b>12</b> Day <b>31</b> Year <b>56</b> a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>1-21-57</b> to <b>12-31-56</b> and last saw her alive on <b>Dec 4-56</b> Death occurred at <b>12:50 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>David W. Brano</b> (Dr or title)				22b. ADDRESS <b>No 2 Kirksville, Mo</b>			22c. DATE SIGNED <b>1-4-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-3-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kirksville, Mo.</b>				
24. FUNERAL DIRECTOR <b>Haris &amp; Haris</b> ADDRESS <b>Kirksville, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1-5-57</b>		26. REGISTRAR'S SIGNATURE <b>David W. Ratliff</b>				

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

335-

JAN 16 1957

SEP 26 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert B. Davis*  
.....

Licensed Embalmer No. 4219

P. O. Address Kirksville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.