

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Health,  
& Welfare  
Public  
ServiceWakeman  
FILED NOV 18 1957

Registration District No. 128 Primary Registration District No. 2000

Registrar's No. 1096

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b> 0386	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>Baptist Hospital</b>		Length of stay in 1b <b>50 Yrs.</b>	
d. STREET ADDRESS <b>827 S. Patton</b>		(If outside, give location) <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>WAITE</b> Last <b>WAITE</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10,</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Apr. 1901</b>
9. AGE (In years last birthday) <b>56</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Kansas</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Izaac McKnight</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Russell</b>	14. NAME OF HUSBAND OR WIFE <b>Edwin Waite</b>
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. <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b> Address
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>Cerebral Hemorrhages with hemiplegia left complete</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
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? <b>NO</b>
20a. ACCIDENT * SUICIDE: HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>331X</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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>Oct 8, 57</b> to <b>11-10-57</b> and last saw her alive on <b>11-10-57</b> Death occurred at <b>11:35 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. Newton Wakeman M.D.</b> (Degree or title)		22b. ADDRESS <b>Springfield, Mo.</b>	
		22c. DATE SIGNED <b>11-12-57</b>	
23a. BURIAL: CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-14-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>	23d. LOCATION (City, town, or county) (State) <b>Republic Mo.</b>
24. FUNERAL DIRECTOR <b>J. Kleigner &amp; Co - Spgfd. Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>11-14-57</b>	26. REGISTRAR'S SIGNATURE <b>Walter Williamson</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Green

White

Green

South

837 E. Denton

Barrett Hospital 50 Yrs

1957

Nov. 10

White

White

837 E. Denton

x

White

Female

USA

Home

Home

Home

Barrett Hospital

Barrett Hospital

Barrett Hospital

Barrett Hospital

Barrett Hospital

Barrett Hospital

No

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 *May Rhode*

11-1-57

Licensed Embalmer No. 4071

P. O. Address *Springfield*

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.