

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009627

STATE FILE NUMBER

FILED APR 15 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 384

300
-57

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hosp.		Length of stay in lb 5 yrs.	d. STREET ADDRESS (If outside, give location) 1628 S. Robberson		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Sanford Middle Wayland Last Wayland			4. DATE OF DEATH Month April Day 8 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1907	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months 1 Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Appliances		11. BIRTHPLACE (City and state or country) Izard County, Arkansas U. S. A.	
13a. FATHER'S NAME Jeff Wayland		13b. MOTHER'S MAIDEN NAME Della May		14. NAME OF HUSBAND OR WIFE Meck 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. 432-26-4241		17. INFORMANT Address Meck Wayland-Springfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia					INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 77 hrs. 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Acute Nephrosis					
DUE TO (c) Spinal Cord Hemorrhage 357X					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute Yellow Atrophy of Liver - Terminal Pneumonia					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 9:30 a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 3 April, 58 to 8 April, 58 and last saw him alive on 8 April, 58 Death occurred at 9:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE D. M. Kolze M.D. (Degree or title)			22b. ADDRESS Springfield, Mo.		22c. DATE SIGNED 4/10/58
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE 4-11-1958	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Missouri.
24. FUNERAL DIRECTOR [Signature] ADDRESS Springfield, Mo.			25. DATE RECD. BY LOCAL REG. 4-11-58		26. REGISTRAR'S SIGNATURE Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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  _____

Licensed Embalmer No. 3312
P. O. Address Springfield, M

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.