

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004592

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 105 STATE FILE NUMBER

FILED VS FEB 20 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Length of stay in 1b <u>51 minutes</u>	c. CITY OR TOWN <u>Armstrong</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.R. 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Susan Kathleen Wayland</u>			4. DATE OF DEATH Month Day Year <u>2 13 61</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>49</u>
11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joe Wayland</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Saller</u>	14. NAME OF HUSBAND OR WIFE
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 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) <u>ASphyxia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CONGENITAL ATELECTASIS Bilateral</u> DUE TO (c) <u>Hypoplasia Left Lung</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CONGENITAL Hernia Left Diaphragm.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>49 minutes</u>
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 a.m. p.m. Month, Day, Year	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 <u>2-13-61; 10<sup>44</sup> pm</u> to <u>2-13-61 11:35<sup>PM</sup></u> and last saw her alive on <u>2-13-61 11:35 PM</u> . Death occurred at <u>1:35 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (If nurse or title) <u>William J. Tuffin MD</u>		22b. ADDRESS <u>U M M C</u>	22c. DATE SIGNED <u>2-13-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 14, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Armstrong</u>	23d. LOCATION (City, town, or county) (State) <u>Armstrong, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mrs. Stuart Parker, Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 15 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>

**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 George D. Trammell

Licensed Embalmer No. 4425

P. O. Address Columbia,

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.