

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-020453

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 5

FILED JUN 13 1963

VS 300
Rev. 4/59

1 7002

2 7002

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9 157X

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12 86-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>GRANDVIEW</u>		c. CITY OR TOWN <u>GRANDVIEW</u>	
c. FULL NAME OF (IF NOT IN HOSPITAL, give location) HOSPITAL OR INSTITUTION <u>GRANDVIEW NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>1412 E 133rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL ERWIN WAYNICK</u>		4. DATE OF DEATH Month Day Year <u>6 8 1963</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1926</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHARITON IOWA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>HENRY C. WAYNICK</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH WEST</u>	14. NAME OF HUSBAND OR WIFE <u>Nella Waynick</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		17. INFORMANT Address <u>16 C. Mo. 363 Loyd Waynick 9509 E 64th Terr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u>			<u>72 hrs</u>
DUE TO (b) <u>METASTATIC CARCINOMA</u>			<u>6 mo</u>
DUE TO (c) <u>CARCINOMA PANCREAS</u>			<u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ to _____ and last saw him alive on <u>6/7/63</u> . Death occurred at <u>8:00 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Boyd L. Harris M.D.</u>		22b. ADDRESS <u>Grandview Missouri</u>	22c. DATE SIGNED <u>6-11-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6-10-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glendale Cem. Des Moines, Iowa</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS <u>HINTON FUNERAL HOME, Raytown, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-11-63</u>	26. REGISTRAR'S SIGNATURE <u>Delbert Goddard</u>

(Licensed Embalmer's Statement on Reverse Side)

STATE OF MISSISSIPPI

JUN 19 1961

1008
1008
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1214
0-28
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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 _____ Signed Forrest D. Coldenow
Signature of Student Embalmer

Licensed Embalmer No. 4714

P.O. Address K. C. W.

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.