

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-031892

STATE FILE NUMBER

Registration District No. 120 Primary Registration District No. 4194 Registrar's No. 85

**FILED SEP 4 1963**

1. PLACE OF DEATH a. COUNTY <b>Gentry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Albany</b>		Length of stay in 1b <b>Lifetime</b>	c. CITY OR TOWN <b>Albany, Missouri</b> <b>403 E. Clay</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>403 E. Clay</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>403 E. Clay</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY ELIZABETH WAYMAN</b>			4. DATE OF DEATH Month Day Year <b>August 31, 1963</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/6/1870</b>
9. AGE (last birthday) <b>92</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Gentry Co., Missouri</b>
13a. FATHER'S NAME <b>Henry Parman</b>		13b. MOTHER'S MAIDEN NAME <b>Harriot Colvin</b>	14. NAME OF HUSBAND OR WIFE <b>Manuel Wayman</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>no</b>		16. SOCIAL SECURITY NO. <b>[redacted]</b>	17. INFORMANT Address <b>Mrs Oscar Adams Albany, 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>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Atherosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>12 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive Heart Disease and Rheumatoid</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Month, Day, Year 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>26 August</b> to <b>31 August 1963</b> and last saw her alive on <b>August 30, 1963</b> Death occurred at <b>1:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Fred B. Morgan, M.D.</b>		22b. ADDRESS <b>Albany, Missouri</b>	22c. DATE SIGNED <b>Aug. 31, 1963</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Sept 2, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grandview</b>	23d. LOCATION (City, town, or county) <b>Albany, Missouri</b>
24. FUNERAL DIRECTOR <b>Brooks-Cochell Funeral Home Albany, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-31-'63</b>	26. REGISTRAR'S SIGNATURE <b>Mr. L.W. Base</b>

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Troy O. Morgan - M.D.

Rec'd 8-31-63

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 me, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Donald E. Coakley

Licensed Embalmer No. 4868

P. O. Address Albany, Mo.

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.