V. S. No. 2
OM—9-4-41
ev. 5-17-39
I X29484

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26531

FILED SEP 3 1942

Registration District No. 249

Primary Registration District No. 1002

Registrar's No. 3102

1. PLACE OF DEATH:

(a) County Jackson,
(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lakeside Hospital, O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day, (Specify whether
In this community 38 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48
(c) City or town Kansas City, 8
(If outside city or town limits, write "RURAL")
(d) Street No. 906 Paseo,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x O

3. (a) PRINT FULL NAME John G. Wayland,

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Male O

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary S. Wayland,

6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased July (Month) 7 (Day) 1870 (Year)

8. AGE: Years 72 Months 1 Days 8 If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) O (State or foreign country)

10. Usual occupation Manager

11. Industry or business Sav. Dept. Traders Gate City Nat'l. Bank

FATHER
12. Name Joseph Wayland,
13. Birthplace Missouri (City, town, or county) O (State or foreign country)

MOTHER
14. Maiden name Catherine "unknown"
15. Birthplace Unknown, (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Mary S. Wayland,
(b) Address 906 Paseo, Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-42 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C. Mo.

19. (a) 8-17-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15th year 1942 hour 8:10 minute P. M.

21. I hereby certify that I attended the deceased from Aug. 14 - 9:00 a.m. 1942, to Aug 15, 1942 that I last saw him alive on Aug 15, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis (with rupture of L. Ventricle) (autopsy)	2 days
Due to with Resultant Hypostatic pneumonia	
Due to Thrombosis of Left Coronary artery	9 40
Other conditions (Include pregnancy within 3 months of death) Beginning arteriosclerosis	

Major findings:
Of operations
Of autopsy Coronary Thrombosis + Rupture of L. ventricle

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no -
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? —
(Specify type of place)
While at work? — (e) Means of injury — 2

23. Signature [illegible] (M. D. or other) D.O.
Address Lakeside Hospital Date signed 8-17-42

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(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1 4 1 5

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.