

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

FILED AUG 27 1949 149
Registration District No. _____

Primary Registration District No. 1002

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:
Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since Birth
(Specify whether _____)
In this community 13 Hours
years, months or days

3. (a) PRINT FULL NAME Robert Ray Wayman

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 13 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 13 hr. _____ min.

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

10. Usual occupation Child

11. Industry or business None

MOTHER FATHER { 12. Name Robert Wayman
13. Birthplace Riverton Nebraska
(City, town, or county) (State or foreign country)
14. Maiden name Loretta Franke
15. Birthplace Great Bend Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Wayman
(b) Address 2826 Wabash Avenue

17. (a) Cremation (b) Date thereof Aug 16, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer
(b) Address 1401 Brush Creek Blvd.

19. (a) 8-16-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2826 Wabash Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14th
year 1943 hour 9:00 minute 50P. M.

21. I hereby certify that I attended the deceased from Aug 13th 1943 to Aug 14th 1943
that I last saw him alive on Aug 14th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Edema of Brain
Due to Failure of Bones of Skull to close
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
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) _____
(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? _____

While at work? _____ (Specify type of place)
Means of injury _____
23. Signature Dr. Joseph S. Peterson (M. D. or other) Dr. L. L. Brown
Address 1219 9th St. Bldg Date signed 8-15-43

Handwritten notes and signatures in the top left corner, including a signature that appears to be "K. C. Moore" and some illegible text.

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 *K. C. Moore*
Licensed Embalmer No. 4043
P. O. Address *K. C. Moore*

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.