

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 126

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> 3008	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (In this place) <u>2 1/2</u> days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>		d. STREET ADDRESS (If rural, give location) <u>not given</u>	

3. NAME OF DECEASED a. (First) <u>Jesse</u> b. (Middle) <u>---</u> c. (Last) <u>Waymire</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 31 1950</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Joseph Waymire</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Patterson</u>	14. NAME OF HUSBAND OR WIFE <u>never married</u>
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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'S SIGNATURE OR NAME ADDRESS <u>Mrs. E. W. Waymire Springfield, Mo 1623 Summit</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Interochanteric fracture of left femur Dec 5 49</u> DUE TO (c) <u>Epilepsy</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) <input checked="" type="checkbox"/> SUICIDE <u>accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Bank Bldg. 2</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph Buchanan Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Nov. 15 1949 m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell out of bed during seizure fractured left neck of femur</u>

22. I hereby certify that I attended the deceased from Dec 1, 1949, to Jan 31, 1950, that I last saw the deceased alive on Jan 31, 1950, and that death occurred at 6:50 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>	23b. ADDRESS <u>St. Joseph Mo. at State Hospital no 2</u>	23c. DATE SIGNED <u>2/1 1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 3, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>State Hosp. #2</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Feb. 7, 1950</u>	REGISTRAR'S SIGNATURE <u>E. C. Jenkins</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Stoney Funeral Home - St. Joseph, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

*no Embalming
permt*

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
Student Embalmer

Signed *Charles M. Harman*

Licensed Embalmer No. *4487*

P. O. Address *St. Joseph*

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.