

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2384**

FILED JAN 23 1952

BIRTH NO. _____ REG. DIST. NO. **291** PRIMARY REG. DIST. NO. **3056** Registrar's No. **16**

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give town) Moberly	c. LENGTH OF STAY (in this place) 2 hours	c. CITY (If outside corporate limits, write RURAL and give township) Moberly 0883	
d. FULL NAME OF HOSPITAL OR INSTITUTION Woodland Hospital		d. STREET ADDRESS (If rural, give location) 919 South Fifth Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Lucy	b. (Middle) Harriet	c. (Last) Wayland	4. DATE OF DEATH (Month) (Day) (Year) January 9, 1952
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5. SEX female 3	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 1	8. DATE OF BIRTH May 1, 1906	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook	10b. KIND OF BUSINESS OR INDUSTRY Hickory Inn	11. BIRTHPLACE (State or foreign country) Prairie Hill, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME John Turner	13b. MOTHER'S MAIDEN NAME Sarah Dameron	14. NAME OF HUSBAND OR WIFE Wanzo Wayland
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NUMBER (If yes, give way or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Wanzo Wayland	ADDRESS 919 S. 5th; Moberly
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Jan 8 / 52 Jan 9 / 52
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 _____	334X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **Jan 8**, 1952, to **Jan 9**, 1952, that I last saw the deceased alive on **Jan 9**, 1952, and that death occurred at **P. m.**, from the causes and on the date stated above.

23a. SIGNATURE cc Smith MD (Degree or title)	23b. ADDRESS Moberly, Mo.	23c. DATE SIGNED Jan 12-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-12-1952	24c. NAME OF CEMETERY OR CREMATORY Roanoke Cemetery	24d. LOCATION (City, town, or county) (State) Roanoke, Missouri
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DATE REC'D BY LOCAL REG. 1-12-52	REGISTRAR'S SIGNATURE C. L. ...	25. FUNERAL DIRECTOR'S SIGNATURE J. B. Patton & Sons	ADDRESS Hunterville, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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
Student Embalmer

Signed Paul J Patton

Licensed Embalmer No. 4095

P. O. Address Huntsville, 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 this body is not embalmed, fact should be so stated above.