

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 11 1957

57 0 2 2 9 8 3
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6240**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Length of stay in 13 DAYS	d. STREET ADDRESS (If outside, give location) 289 STREET ADDRESS 1436a ROWAN AVE.
3. NAME OF DECEASED (Type or print) JOHN LOYD WAYMER		First Middle Last	4. DATE OF DEATH Month 7 Day 4 Year 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-99
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CAIRO, ILLINOIS
13. FATHER'S NAME LEMUEL B WAYMER		14. MOTHER'S MAIDEN NAME ROSE ANN DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW 1		16. SOCIAL SECURITY NO. 289-10-6853	17. INFORMANT Address MISSOURI. VA HOSP. RECORDS. 915 N GRAND ST LOUIS,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 330x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PYELONEPHRITIS AND CYSTITIS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. Attended the deceased from 6-24-57 to 7-4-57 and last saw RECORDED HIM 7-4-57 Death occurred at 9:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. E. Ash		22b. ADDRESS M. D. VAH. ST. LOUIS, MISSOURI	22c. DATE SIGNED 7-4-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/5/57	23c. NAME OF CEMETERY OR CREMATORY Clarkson, Ky	23d. LOCATION (City, town, or county) (State) Clarkson, Ky
24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Blvd.		25. DATE RECD. BY LOCAL REG. JUL 5 '57	26. REGISTRAR'S SIGNATURE Carl Smith M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 _____
Signature of Student Embalmer

Signed _____
Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.