

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032641

FILED VS OCT 7 1959

4560

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>UNK.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OSTEOPATHIC HOSE</u>		d. STREET ADDRESS (If outside, give location) <u>4000 N. BRIGHTON</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgia Marie Wayman</u>			4. DATE OF DEATH Month Day Year <u>SEPT 17 1959</u>			
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-1908</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Midwest Chandler Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CONVERSE, MO</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>EVERETTA PAINTER</u>	13b. MOTHER'S MAIDEN NAME <u>NANCY D. BAKER</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN E WAYMAN</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>490-24-3319</u>	17. INFORMANT <u>JOHN E WAYMAN 4000 N. BRIGHTON</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Congestive failure 2 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Metastatic Carcinoma</u>		<u>1 Yr.</u>
DUE TO (c) <u>Adenocarcinoma of Sigmoid Colon</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from <u>5-23-59</u> to <u>9-17-59</u> and last saw her/him alive on <u>9-12-59</u> Death occurred at <u>1:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul Morrison D.O.</u>	22b. ADDRESS <u>2014 Swift, North K.C.</u>	22c. DATE SIGNED <u>9-18-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>CLAY Co. MO.</u>
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24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons N.K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-19-59</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

PAC L1 MORTIS ON BY AFFIDAVIT OF

Dr. Morrison
Horsley Clinic
Apr 10 30 A.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John W. Henrich

Licensed Embalmer No. 4848

P. O. Address K. C. 172

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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