RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

LED VS AUG 8 1960

-60-028915

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7338

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Franklin
c. CITY OR TOWN: St. Clair
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: OTTO Middle: R. Last: WAYNE
4. DATE OF DEATH: Month: JULY Day: 21 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Sep. 23, 1898
9. AGE (last birthday): 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Shoe Factory
11. BIRTHPLACE (City and state or country): Blackwell, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Frank Wayne
13b. MOTHER'S MAIDEN NAME: Nora Reed
14. NAME OF HUSBAND OR WIFE: Florence Wayne
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Florence Wayne Address: St. Clair, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADENOCARCINOMA OF RIGHT LUNG WITH CEREBRAL AND LIVER METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 2 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 163X
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

BY AFFIDAVIT OF

21. I attended the deceased from JAN. 25, 1960, to JULY 21, 1960 and last saw her/him alive on JULY 21, 1960
Death occurred at 5:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: G. Vermillion, M.D. (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 7/23/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 24, 1960
23c. NAME OF CEMETERY OR CREMATORY: Grubville Cemetery
23d. LOCATION (City, town, or county) (State): Grubville, Mo.
24. FUNERAL DIRECTOR: Casey-Lenox ADDRESS: St. Clair, Mo.
25. DATE RECD. BY LOCAL REG.: JUL 23 1960
26. REGISTRAR'S SIGNATURE: Hal Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

H.T.

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed K. M. Lewis, Jr.

Licensed Embalmer No. 5090

P. O. Address St. Louis,

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