

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007126

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1452

STATE FILE NUMBER

**FILED MAR 15 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
Ruth Andrews

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		Length of stay in 1b <b>50 YRS.</b>	c. CITY OR TOWN <b>KANSAS CITY</b>
c. FULL NAME OF (If NOT in hospital, give location) <b>North Fleet &amp; Little Blue Rd.</b>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. STREET ADDRESS (If outside, give location) <b>North Fleet &amp; Little Blue Rd.</b>
3. NAME OF DECEASED (Type or print) <b>Gertrude Scott Wayland</b>		First Middle Last	4. DATE OF DEATH <b>March 2 1963</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>87</b>
13a. FATHER'S NAME <b>Wm. Wortman Gilson</b>		13b. MOTHER'S MAIDEN NAME <b>G. May Francis</b>	14. NAME OF HUSBAND OR WIFE <b>Jess E. Wayland</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Jess E. Wayland North Fleet &amp; Little Blue Rd.</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>General arterio sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Coronary sclerosis</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 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
21. I attended the deceased from <b>June 22 1962</b> and last saw her alive on <b>March 2 1963</b> Death occurred at <b>9:06 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Ruth Andrews, D.O.</b>		22b. ADDRESS <b>Independence Mo.</b>	
22c. DATE SIGNED <b>3/3/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>3-4-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM. KANSAS CITY Mo.</b>	
24. FUNERAL DIRECTOR <b>HINTON FUNERAL HOME Raytown, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-4-63</b>	26. REGISTRAR'S SIGNATURE <b>Ruth H. Long</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 Forest D. Colman

Licensed Embalmer No. 4714

P. O. Address K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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