

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

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File No. _____
Registered No. 1030
St. _____ Ward _____

1. PLACE OF DEATH

County Ruelanau
Township _____
City St. Joseph (No. _____) State Hospital #2.

Registration District No. _____
Primary Registration District No. _____
State Hospital #2.

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

Wm. A. Combs Mary A. Combs
Lexington, Mo.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Willis Combs

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov, 22, 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
54 9 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lexington Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Silas A. Wyatt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lexington Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sarah A. Allen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Salmon New Jersey
(STATE OR COUNTRY)

14. INFORMANT Mildred B. Combs
(Address) 1921 Washington, Lexington, Mo.

15. FILED 3 1920
John G. Webb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 2 1929

17. I HEREBY CERTIFY, That I attended deceased from _____
Aug. 24th, 1929, to Sept. 2nd, 1929
that I last saw h.l.f. alive on Sept. 1st, 1929, and that death occurred, on the date stated above, at 12:05 - P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
1097 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Lunatic
04 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? 1000
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. Dewey, M. D.

9/2, 1929 (Place) St. Joseph, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Henrietta, Missouri DATE OF BURIAL Sept, 3, 1929

20. UNDERTAKER Walter Meinkoffer ADDRESS 1302 Faraon St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. 22-1929 6-9-24

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